KISKÂYITAMAWIN MIYO-MAMITONECIKAN[1]

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URBAN ABORIGINAL WOMEN AND MENTAL HEALTH

Roberta Stout
June 2010

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is a Plains Cree word which means
"knowing mind *fullness*"

Project #215

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AND MENTAL HEALTH

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PRAIRIE WOMEN'S HEALTH
CENTRE OF EXCELLENCE
RESEARCH ■ POLICY ■ COMMUNITY

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Acknowledgments

I'm going to get help. I am determined.

'Cause if I don't get help, I'm worried that

I'm going to lose everything I have.

And I just don't think that

anybody understands that.

— Interviewee

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ACRONYMS

AHF	Aboriginal Healing Foundation
AFN	Assembly of First Nations
CWHN	Canadian Women's Health Network
CCPA	Canadian Centre for Policy Alternatives
FNIHB	First Nations and Inuit Health Branch
INAC	Indian and Northern Affairs Canada
IPHRC	Indigenous Peoples' Health Research Centre
ITK	Inuit Tapiriit Kanatami
MWAC	Mental Wellness Advisory Committee
NAHO	National Aboriginal Health Organization
NCCAH	National Collaborating Centre for Aboriginal Health
NWAC	Native Women's Association of Canada
PWHCE	Prairie Women's Health Centre of Excellence
RHS	First Nations Regional Longitudinal Health Survey

EXECUTIVE SUMMARY

Introduction

A research team from the Prairie Women's Health Centre of Excellence (PWHCE) conducted community-based interviews and focus group sessions with 46 Aboriginal women from Winnipeg and Saskatoon to talk about their mental health concerns, needs and coping strategies, and particularly to gather their suggestions on how to better improve the mental health services, programs and supports. This report seeks to fill a gap in the current understandings of mental health through unique and diverse community-based perspectives and narratives of Aboriginal women.

Methods

A total of forty-six Aboriginal women from Saskatoon and Winnipeg participated in the research. The project centred on conversations with the women, through one-on-one interviews and focus group discussions held between September 2009 and February 2010. Participants were primarily recruited through the distribution of posters, email and word of mouth with Aboriginal community organizations, educational institutions, and women-based agencies.

City	Participants
Saskatoon	⇨ 13 focus group participants ⇨ 7 individual interview participants ⇨ individual interviews: 1 Elder, 1 front-line worker, 1 researcher
Winnipeg	⇨ 11 focus group participants ⇨ 10 individual interview participants ⇨ individual interviews: 1 Elder, 1 front-line worker

This final report is a collection of the personal and professional narratives, opinions and recommendations from all the women who participated in the project, including those interviewed individually and those who participated in the focus group discussions. More information on the methodology will be included in Section 1.

The women and their stories

Participants were each at different places along their mental health journey and their use of mental health services. Some had yet to disclose their mental illness to family members and were unaware of the services and supports available to them. Others could be seen as "veterans" of the mental health system who have struggled

for a decade or more to get the "right" programming to meet their needs. Many expressed frustration over the barriers generally plaguing the mental health services, programs and supports. At the same time there was optimism for better mental health outcomes.

Front-line workers, Elders and a representative of the mental health research community provided other insights into the cultural, program and policy areas of the mental health services and programs. Greater detail of participant demographics will be provided in Section 1 of this report.

Sections two through five of the report will present the main findings from the interviews and focus group discussions.

To begin, section two looks at the lifelong experiences expressed by many of the women. They explained how experiences of physical, sexual, emotional or mental abuse in childhood, or being passed from foster home to foster home, have affected their mental health from childhood to adulthood. The general sense is that many of the women felt a lack of control over their young lives and didn't feel that they had rights as children. They spoke of emotional distancing and distrust in family and community in childhood. Their forming identities were rattled by the constant and ever-present onslaught of racism and discrimination, which they clearly saw as rooted in colonization and ongoing colonial policies and practices.

Section three takes a closer look at the definitions of mental health, principally from an Aboriginal perspective, but more specifically through the lens of the women themselves. Herein they spell out what mental health and mental illness means to them, and provide insight into their perceptions around their past or current state of mental health. This section explores their often complicated and frustrating experiences with stigma (both internalized and externalized) and use of medications. The final piece to this section describes how the women have created uniquely personal and collective strategies for self-care and coping with their mental illness.

Section four sets out to look specifically at the barriers identified by the women that stop them from seeking out, receiving or accessing the appropriate services and programs to help them with their mental health. While the majority of the women have sought help in one form or another, many continue to be confused and disgruntled with current mental health services and programs.

Their articulate and thoughtful criticisms of mental health services and programs point to clear opportunities to move towards better outcomes. Section five of the paper looks at their collective and broadly defined mental health needs which include: the need to be heard and receive answers; the need to talk to someone; and the need for care, support and acceptance.

The paper concludes by summarizing the concrete suggestions and recommendations coming from the women about how they would adapt and make changes to the mental health services and programs to better meet their needs.

They collectively envisage a care system that is collaborative and draws upon both Traditional and Western-based approaches. Their experiences with the mental health services and programs point to a shared need to be heard, believed, and treated with respect. This ideal system would also promote culturally appropriate, safe care while staying away from a cookie-cutter approach that fails to account for the diversity of Aboriginal peoples. The following are their community-based recommendations.

❖ *Listen to the community for solutions on improving mental health*

❖ *Develop more early intervention programming*

❖ *Break down the barriers to finding mental health support and help*

❖ *Make sure that mental health resources and information are available to Aboriginal women and the community at large*

❖ *Create around the clock, in-person mental health care services*

❖ *Increase culturally-grounded and appropriate programs*

❖ *Promote more opportunities for healing*

❖ *Establish a one-stop mental health clinic*

❖ *Build a collaborative care model for mental health*

❖ *Raise awareness around mental health*

❖ *Provide more programming focusing on life skills development*

❖ *Create more drop-in centres for Aboriginal women*

❖ *Increase opportunities for mental health aftercare programs*

❖ *Ensure there is adequate and long-term funding provided to mental health programming for Aboriginal women*

POLICY IMPLICATIONS

1. **Examine how cultural (relationships) and structural (policy) level changes can be made to serve and support the mental health and well-being of Aboriginal women in the changing policy climate.**

Cultural changes

   i. Catalyze conversations on everyday forms of mental health and well-being to determine what is working for Aboriginal women in their everyday lives.
   ii. Valorize the stories, experiences, knowledge and wisdom of Aboriginal women who live with mental health problems and illnesses.
   iii. Bring into sharper relief the optimism, pragmatism, resilience and human agency of Aboriginal women living with mental health illnesses.
   iv. Understand the impacts of residential schools, foster care and the bio-medical model of health care lived by Aboriginal women by taking a critical look at multiples risks they experience and the protective practices they, their families, and communities of care each utilize.

Structural changes

   i. Factor in gender, sex, cultural and class differences for Aboriginal women with lived mental health experiences in order to better define, identify and remedy their health disparities and inequities.
   ii. Provide mental health services and supports to Aboriginal women close to home by encouraging the practice of home visits by caregivers.
   iii. Monitor and use ready, relevant and multiple interventions for Aboriginal women by acknowledging and working with what they say has worked best for them to date without over-medicalizing their mental health problems or over-pathologizing their responses.
   iv. Cultivate a sense of belonging, usefulness and importance amongst Aboriginal women with lived mental health experiences.

2. **Conduct research on the meaning and application of an Aboriginal lens when addressing the mental health and well-being of Aboriginal women.**

   i. Deepen the public understanding of the worldviews of Aboriginal women emphasizing the wholeness of the mind, body and spirit but also by examining the women's views of the world which they

generally experience as unjust and unfair socially, economically, culturally and politically.

ii. Wherever possible use Aboriginal concepts and emerging community-based practices to explain mental health and well-being of Aboriginal women and to determine the ethical and healing aspects of these.

iii. Invite Aboriginal women with lived experiences to develop interactive learning tools for their health care providers, families and one another (i.e. role plays, poetry, art, songs that would incorporate oral traditions and examples of mental health and well-being).

iv. Utilize a gender balanced framework in further research on Aboriginal women's mental health.

3. **Reframe mental health services and supports so they mirror Aboriginal women's realities, living conditions and aspirations for hope and recovery.**

i. Improve Aboriginal women's access to mental health services and supports and enhance their attachment to these by creating compassionate, solidarity-based, trusting and confidential programming.

ii. Explore the multiple burdens of stigma and discrimination that Aboriginal women face, including self-stigma and racism, to see how cultural competency and cultural safety can help to offset these.

iii. Recognize that the social roots of mental health problems stem from deep, long-standing childhood trauma, including sexual abuse, poor infant bonding and attachment and from current issues like homelessness, poverty and suicidality and how these can lead to a cluster of chronic mental health and physical health problems.

iv. Reflect nested identities (i.e. ethnic, cultural, religious, abilities etc.) by tailoring services and supports to the particular needs of Aboriginal women-in-community to avoid pan-Aboriginal approaches and cookie-cutter interventions.

4. **Develop mental health services and supports from evidence-based practice and practice-based evidence.**

i. Fully integrate the ideas, interests and perspectives of Aboriginal women into the design, delivery and evaluation of mental health services, supports and programs.

ii. Offer both Traditional and Western healing approaches to Aboriginal women and assist them once they make a choice by providing transportation and childcare services and by paying attention to the power relations they have to deal with.

iii. Emphasize mental health promotion and mental illness prevention along with diagnosis and treatment by providing mental health

literacy training for health and social services professionals and mental health first-aid training to family and friends.

iv. Advocate person-centered care for Aboriginal women with lived mental health experiences and direct initiatives to them including peer support and interactive learning opportunities.

v. Recognize the prevalence of the co-morbidity of mental health problems and addictions by drawing on studies and looking for gaps in knowledge, resources and capacity.

Résumé

Introduction

Une équipe de recherche du Centre d'excellence pour la santé des femmes – région des Prairies (CESFP) a mené des interviews et des séances de groupes de réflexion au sein des collectivités faisant intervenir 46 femmes autochtones de Winnipeg et de Saskatoon dans le but de discuter de leurs préoccupations en matière de santé mentale, de leurs besoins et de leurs stratégies d'adaptation, et en particulier, dans le but d'obtenir leurs suggestions sur les moyens d'améliorer davantage les services, les programmes de santé mentale et les soutiens. Le présent rapport a pour objectif de combler une lacune de la compréhension actuelle de la santé mentale en offrant les perspectives et les récits communautaires des femmes autochtones qui sont uniques et divers.

Méthodes

Un total de quarante-six femmes autochtones de Saskatoon et de Winnipeg ont participé au projet de recherche. Le projet fut axé sur les entretiens auprès des femmes, sur les interviews individuelles et sur les discussions des groupes de réflexion qui ont eu lieu entre septembre 2009 et février 2010. On a recruté les participantes principalement par la distribution d'affiches et de messages électroniques envoyés aux organismes communautaires, aux établissements scolaires et aux agences à l'intention des femmes autochtones, et par la transmission de bouche à oreille.

Ville	Participantes
Saskatoon	⇨ 13 participantes aux groupes de réflexion ⇨ 7 participantes aux interviews individuelles ⇨ interviews individuelles : 1 ancienne, 1 travailleuse de première ligne, 1 chercheuse
Winnipeg	⇨ 11 participantes aux groupes de réflexion ⇨ 10 participantes aux interviews individuelles ⇨ interviews individuelles : 1 ancienne, 1 travailleuse de première ligne

Le rapport final se veut un recueil des récits, des points de vue et des recommandations personnels et professionnels de toutes les femmes qui ont participé au projet, y compris celles qui ont été interviewées individuellement et celles qui ont participé aux discussions des groupes de réflexion. D'autres renseignements sur la méthodologie figurent à la Section 1.

Les femmes et leurs histoires

Les participantes en étaient toutes à un point différent sur le continuum de leur santé mentale et de leur utilisation des services de santé mentale. Certaines n'avaient toujours pas fait part de leur maladie mentale aux membres de leur famille et n'étaient pas conscientes des services et des soutiens à leur disposition. D'autres qui avaient lutté pendant une décennie ou plus en vue d'obtenir le « bon » programme qui répondrait à leurs besoins auraient pu être qualifiées d'« habituées » du système de santé mentale. De nombreuses femmes ont exprimé leur frustration face aux obstacles qui minent de façon générale les services, les programmes de santé mentale et les soutiens. En même temps, elles étaient optimistes pour ce qui était de meilleurs résultats futurs en santé mentale.

Des travailleuses de première ligne, des anciennes et une représentante de la communauté de recherche en santé mentale ont offert d'autres interprétations relevant des domaines de la culture, des programmes et des politiques liés aux services et aux programmes de santé mentale.

On fournira en plus grand détail les données démographiques des participantes dans la Section 1 du présent rapport. Les sections 3, 4 et 5 du rapport fourniront les principales conclusions des interviews et des discussions des groupes de réflexion.

Le début de la Section 3 passe en revue les expériences du vécu de nombreuses femmes telles qu'exprimées par celles-ci. Elles expliquent comment les expériences d'abus physique et sexuel, de violence émotive ou psychologique de leur enfance, ou leur expérience d'avoir passé d'un foyer nourricier à un autre ont affecté leur santé mentale de l'enfance à l'âge adulte. En général, le sentiment de nombreuses femmes était qu'elles croyaient n'avoir exercé aucun contrôle sur leur jeunesse et qu'elles n'avaient aucun droit à titre d'enfant. Elles ont exprimé un sentiment de détachement affectif et de méfiance à l'égard des membres de la famille et de la collectivité lors de leur enfance. Le développement de leur identité avait été traumatisé par les assauts continuels et omniprésents du racisme et de la discrimination qu'elles voyaient clairement comme étant enracinés dans le colonialisme et dans les politiques et les pratiques courantes coloniales.

La Section 4 étudie de plus près les définitions de la santé mentale, notamment d'une perspective autochtone, mais plus précisément sous la lentille des femmes mêmes. Dans cette section, les femmes formulent leur propre définition de la santé mentale et de la maladie mentale, et elles nous offrent leur point de vue sur les perceptions de leur état de santé mentale antérieure ou actuelle. Dans cette section, on étudie à fond leurs expériences souvent complexes et frustrantes du stigmatisme (intériorisées et extériorisées) et l'utilisation de médicaments. À la fin de cette section, on décrit les stratégies très personnalisées et collectives que les femmes ont créées dans le but de s'occuper d'elles-mêmes et de composer avec leur maladie mentale.

La Section 4 porte un regard particulier sur les obstacles définis par les femmes qui les empêchent de se chercher des services et des programmes appropriés, de les obtenir ou d'y avoir accès pour les aider à améliorer leur santé mentale. Bien que la majorité des femmes aient cherché de l'aide sous une forme ou une autre, bon nombre d'entre elles continuent à réagir de manière perplexe et à exprimer leur mécontentement face aux services et aux programmes actuels en matière de santé mentale.

Leurs critiques bien exprimées et raisonnées des services et des programmes de santé mentale démontrent clairement qu'il existe des possibilités qui mèneraient à de meilleurs résultats. La Section 4 du rapport concerne leurs besoins collectifs en matière de santé mentale définis au sens large et ils comprennent : le besoin de se faire entendre et d'obtenir des réponses; le besoin de parler avec une autre personne et le besoin d'obtenir des soins, un soutien et d'être acceptée.

La dernière section du rapport résume les suggestions et les recommandations concrètes des femmes qui nous font part des modifications et des changements qu'elles apporteraient aux services et aux programmes de santé mentale de manière à mieux répondre à leurs besoins. Elles envisagent collectivement un système de soins qui se voudrait un système collaboratif et qui ferait appel aux approches traditionnelles et occidentales. Leurs expériences liées aux services et aux programmes de santé mentale signalent un besoin commun de se faire entendre, de se faire croire et de se faire traiter avec respect. Ce système idéal ferait également la promotion des soins sécuritaires et appropriés sur le plan culturel tout en évitant une approche qui convient à tous et qui ne tient pas compte de la diversité des peuples autochtones. Leurs recommandations communautaires sont les suivantes :

- ❖ *Écouter les solutions des membres de la collectivité sur l'amélioration de la santé mentale*
- ❖ *Élaborer d'autres programmes d'intervention précoce*
- ❖ *Enlever les obstacles qui empêchent de trouver un soutien et de l'aide en matière de santé mentale*
- ❖ *S'assurer que les ressources et les renseignements liés à la santé mentale soient offerts aux femmes autochtones et à toute la collectivité*
- ❖ *Mettre en place des services offerts 24 heures sur 24, des services de soins de santé mentale individuels*
- ❖ *Augmenter le nombre de programmes appropriés et axés sur la culture*
- ❖ *Faire la promotion de plus d'occasions de rétablissement*
- ❖ *Mettre sur pied une clinique de santé mentale à guichet unique*
- ❖ *Créer un modèle de soins collaboratifs en matière de santé mentale*
- ❖ *Sensibiliser davantage les personnes à la santé mentale*

- ❖ *Fournir plus de programmes axés sur le développement des compétences de la vie autonome*
- ❖ *Mettre sur pied plus de haltes-accueil à l'intention des femmes autochtones*
- ❖ *Accroître les possibilités de programmes de suivi en matière de santé mentale*
- ❖ *Assurer un financement adéquat et à long terme aux programmes de santé mentale destinés aux femmes autochtones*

SECTION ONE:

INTRODUCTION AND BACKGROUND TO THE PROJECT

Introduction

A research team from Prairie Women's Health Centre of Excellence (PWHCE) conducted community-based interviews and focus group sessions with 46 Aboriginal women from Winnipeg and Saskatoon to talk about their mental health concerns, needs and coping strategies, and particularly to gather their suggestions on how to better improve the mental health services and programs. This report seeks to fill a gap in the current knowledge on understanding mental health through the unique and diverse community-based perspectives and narratives of Aboriginal women. More specifically the research sought to answer the following five questions:

1. What are the key factors influencing Aboriginal women's mental health?
2. What does mental health mean to Aboriginal women?
3. Are Aboriginal women aware of and/or using available mental health resources?
4. What are Aboriginal women's mental health needs?
5. What would Aboriginal women suggest for future policy and program development in the area of mental health?

Background

As part of a response to emerging regional and national health priorities PWHCE proposed an interprovincial (Saskatchewan and Manitoba) exploratory project focusing on the issue of Aboriginal women's mental health. As Aboriginal women's health generally - and their mental health specifically - remain largely unexplored compared with other women's health research in Canada, and as Aboriginal women continue to face numerous barriers to good mental health and well-being, and as the largest concentration of Aboriginal peoples is in the Prairie Provinces, it was appropriate that PWHCE work to explore this priority area. This project aims to continue PWHCE's credible and solid history of work done with, by and for Aboriginal women in the Prairies and across Canada.

At the same time that PWHCE was proposing to look more carefully at the issue of mental health, it was also becoming a topic on the national agenda for Aboriginal and non-Aboriginal organizations alike. Aboriginal organizations, such as the National Aboriginal Health Organization (NAHO) recognized mental health and mental wellness as emerging fields and called for a greater understanding of these areas specific to Aboriginal peoples (Kinnon, 2002). In a chapter related to mental health, wellness and personal support within the First Nations Regional Longitudinal Health Survey 2002/2003 (RHS) it was noted that over the period of

one year 30.1% of First Nations respondents indicated "a time when they felt sad, blue or depressed for two weeks or more in a row" (AFN, 2005).

The First Nations and Inuit Mental Wellness Advisory Committee (MWAC) was also struck in 2005 and brought together a network of representatives and stakeholders from federal/provincial/territorial governments, the Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), and Aboriginal experts in mental health and addictions. This group was tasked with providing "strategic advice to the Community Programs Directorate (CPD) of the First Nations and Inuit Health Branch (FNIHB) of Health Canada on issues related to mental wellness". MWAC has since developed a draft Strategic Action Plan for First Nations and Inuit Mental Wellness (MWAC, 2007).

Similarly, in August 2007, the Honourable Tony Clement, Minister of Health, announced the Government of Canada's $130 million funding commitment to the Mental Health Commission of Canada to improve the quality of life for Canadians and their families dealing with mental illness (Health Canada, 2008). An additional $110 million was committed to the Commission for research projects concerned with homeless Canadians with mental health concerns (Health Canada, c2008).

These recent funding commitments stem from *Out of the Shadows at Last*, the final report of the Standing Senate Committee on Social Affairs, Science and Technology, which made a number of recommendations to transform mental health, mental illness and addiction services in Canada and reduce the stigmatization of mental illness (Kirby, 2006). While the Senate report highlighted a number of issues associated with mental illness, including substance use problems, addictions, homelessness and suicide, it failed to account for the sex and gender differences linked to mental health.

For example, research has shown that women are almost twice as likely as men to experience or be diagnosed with depression. They are also more likely to be prescribed potentially addictive anti-depressant and anti-anxiety medications which also come with serious side effects (CWHN, 2007).

The lack of gender-based analysis in research, programs, and policies for women's mental health has been a continued concern for feminist scholars (CWHN, 2007; 2008a). Much of the research on mental health has neglected to account for sex and gender differences. Consequently, women have long been pathologized and over-medicated while their specific mental health concerns have often been under-recognized or ignored (CWHN, 2006).

Many issues relevant to women's state of mental health remain unclear, but the reality is that women experience a multiplicity of issues in their lives. These often over-lapping issues include mental health concerns, violence, substance use, poverty and homelessness (CWHN, 2008b). Such circumstances are compounded for Aboriginal women who face multiple burdens including sexism, racism, classism. Recent research has revealed that Aboriginal women are about nine times more

likely than non-Aboriginal women to be hospitalized for self-inflicted injuries; indeed, Aboriginal women account for 35% of all such hospitalizations (Donner et al., 2008). According to the 2002/2003 RHS, First Nations women (18.5%) are more likely than First Nations men (13.1%) to attempt suicide over a lifetime (AFN, 2005). Aboriginal women are three times more likely than non-Aboriginal women to die as a result of suicide (Canadian Mental Health Commission, 2008).

The statistics on the mental health issues of Aboriginal women are alarming. This report attempts to bring to light the stories shared by Aboriginal women with lived mental health experiences.

Methodology and procedures

From the outset, it was understood that this project would involve potentially sensitive and triggering topics for participants. With this in mind, the qualitative approach included research principles of consent, confidentiality and accountability and was initially approved by the University of Regina Research Ethics Board in September 2008 and with a revised version submitted in July 2009.

Discussion guides were developed for the focus groups and individual interviews with women, front-line workers, Elders and a representative from the research community. While separate guides were used, they each sought to understand Aboriginal women's concepts of mental health and well-being, key factors impacting the mental health of Aboriginal women, experiences with the mental health services and programs and what would lead to better outcomes for their mental well-being.

Community organizations, service providers and educational institutes, who are known to have high traffic of Aboriginal community women, students and professionals, were approached to loosely collaborate in the project. For example, they were approached to post and email call-outs for participant recruitment. Also the provision of safe, private spaces in which to conduct the interviews and focus groups was requested from them. The two hour focus groups also involved the support of a community Elder.

The one-on-one interviews and focus group discussions drew upon semi-structured, open-ended questions and took anywhere from thirty minutes to over three hours. They took place between September 2009 and February 2010. Discussing mental health often brought up past trauma experienced by the women. The interviewers relied on the women to guide the pace of the discussion and the information they felt comfortable and able to share. The women were not required to speak to every question. They were able to stop the interview or withdraw from the project at any point. Mental health resources were made available at participants' request.

With the exception of the academic interview conducted with Caroline Tait, PhD, all of the women's identities remain anonymous throughout this report due to the sensitivities of their personal stories. The names and workplaces of the front-line

workers and Elders are also not disclosed due to the confidential nature of their work with Aboriginal women clients.

Through the interviews, women's mental health issues and themes around experiences in childhood, teen and adult years surfaced. Beginning with questions specific to childhood and teen years, discussions moved into participants' personal understanding of mental health issues as directly experienced in adulthood. Throughout the interviews, they voiced their personal use and evaluations of mental health programs and services, including their opinions on the efficacy or inefficacy of the care they received. They were then asked to provide a vision around how the system of mental health care can better meet their needs. This visioning process in turn forms the basis for the community-based recommendations of this paper.

Just as the women guided the discussion processes, so too will their voices direct this paper. It will provide insight into their understandings of mental health, their mental health needs, their coping strategies and their recommendations for improving the mental health services and programs for all women.

Limitations

A number of project participants stated that this research is greatly needed and that it is important that community women's voices are brought to the forefront regarding mental health. We recognize that the number of participants in this project is small. This study is therefore not a representative sample of the experiences of all Aboriginal women in Winnipeg or Saskatoon; nor did the time frame and budget allow for research in rural, northern or on-reserve communities. Nonetheless, this small cohort provided rich feedback and insight into Aboriginal women's gendered perspectives on mental health.

Participant demographics

A total of 46 Aboriginal women contributed to this study, with twenty-three participants per city, as seen in the following breakdown.

City	Participants
Saskatoon	⇨ 13 focus group participants ⇨ 7 individual interview participants ⇨ individual interviews: 1 Elder, 1 front-line worker, 1 researcher
Winnipeg	⇨ 11 focus group participants ⇨ 10 individual interview participants ⇨ individual interviews: 1 Elder, 1 front-line worker

While this project is qualitative in nature, there were opportunities to collect some demographic information for a snapshot of the age, identity, education, employment status, income levels and household composition of the 17 individual interviewees. Such information was not collected from focus group participants, Elders, front-line workers or the academic. Importantly though, all of the narratives included in this report consist of the voices of all 46 women participants.

The 17 women who were individually interviewed ranged in age from 18 to 51 years old. The median age was 37. Ten of the women identified as First Nations, four as Métis, one as Non-Status, one as "Aboriginal" and one did not disclose her Aboriginal ancestry. Although the call-out for participants included First Nations, Inuit and Métis, no Inuit women participated in the study.

The women came from a variety of educational backgrounds, some having completed high school, college, or university degrees and some having more limited educational attainment. Over half of the women had not completed high school.

Of the 17 women, five were employed while nine were not; the remaining three participants included a student, a trainee in a mentorship program, and a woman on disability leave.

Each woman was asked whether she had a partner (common-law or spouse) or was single. Of the nine women who identified as the latter, six stated that they were single parents. A total of 10 participants spoke of having dependents still living in their household, anywhere from one to six. Eight disclosed breakdowns in their adulthood relationships with spouses or partners. Four women experienced abuse and/or violence, including domestic violence or abusive partners in adulthood.

While nine women explained that their mental illness began in their child/teen years, five disclosed adulthood onset of their mental illness. Three did not state when their mental illness began. Ten of the women recognized that their mental illness had been associated with negative impacts on family members. As will be shown in a later section of the paper, many of the women's children have demonstrated negative behaviours.

A total of ten women had been diagnosed with a mental health disorder. All 17 had actively sought help for their mental health, through one or more of the following means:

- counseling (10);
- a visit to a psychologist/psychiatrist (14);
- group home or institution (6);
- group therapy/talking circles/sharing circles (6);
- visits with Elders and/or traditional and culturally-based therapies (8).

Of all of those who had sought medical help for their mental illness, 12 stated that they had been prescribed medication; of that number, five spoke of negative

experiences while taking the medication as well as internal conflicts around western-based medicine.

Only four of the 17 women indicated that they were currently in therapy or receiving help. While two women did not indicate one way or the other about their current care situation, a total of eleven stated that they are currently not receiving any care for their mental health. The barriers and mental health needs sections of this paper will shed some light on why women do not, or cannot, access programs and services.

There were mixed reviews on the quality of mental health services received by the women. A total of nine women expressed dissatisfaction and five expressed satisfaction. Three shared no opinion.

While the study did not attempt to uncover a family pattern of mental illness, a total of nine women brought up immediate or extended family members who were also suffering from mental disorders.

When asked about their physical health, 10 women spoke to the diversity of ailments they suffered, such as arthritis, endometriosis, diabetes, high blood pressure, low blood pressure, and obesity. Only two of the women stated that their health was currently good. Five women did not indicate the state of their physical health. Ten of the women also spoke of having experienced poverty in their adult years.

Eleven of the women began to use drugs or alcohol in childhood and teen years and two talked about starting substance use in adult years. A total of seven women were still using alcohol and drugs at the time of this study.

Lifelong experiences

A number of themes emerged for women across their life spans: conflicts around identity, experiences with discrimination and racism, intergenerational impacts of residential schools on their lives and families, attempts or thoughts of suicide, and stigma around mental illness.

Eight women spoke directly of loss or conflicts around cultural identity and/or Aboriginal language in reference to mental health. All but one woman discussed experiencing blatant racism or undertones race-based discrimination during their lifetime. While none of the women in this study had attended residential schools, many indicated that their parents or grandparents did. In total, twelve of the women agreed that these schools have had an enduring impact on their lives and their mental health.

While not specifically asked about in the interview, 12 of the women volunteered that they had experienced suicidal thoughts or attempts during their lives: a number of them had made multiple attempts.

Finally, ten of the women made explicit reference to both internalized and external experiences of stigma as a result of their mental illness. For some, there were situations where internalized stigma made it difficult to seek out specific mental health services within their communities (see section on barriers).

This report will now turn to hearing the unique perspectives and voices of the women who contributed to this study.

SECTION 2

LOOKING BACK OVER A LIFETIME: FRAMING ABORIGINAL WOMEN'S EXPERIENCES

The state of Indigenous people's health, including addictions and mental health,
cannot in Canada be extricated from colonial projects
(de Leeuw, Greewood and Cameron, 2009)

The above quote is an important jumping off point for this section; the mental health of Aboriginal peoples cannot be seen as isolated from colonization and the post-colonial institutions, policies and systems that emerged thereafter. In a 2009 publication, *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada,* authors Kirmayer, Tait and Simpson lay out the social origins of distress. They speak on a deeply rooted history of colonization that has seen the forced cultural, social, linguistic and spiritual assimilation and territorial, political and economic displacement of Aboriginal peoples.

The primary target for assimilation were the children. The colonial policies and practices that removed thousands of Aboriginal children from their families, communities and cultures over one hundred years of residential schooling was replaced by the 'sixties scoop. Over a period of three decades, an ever-increasing number of Aboriginal children became legal wards of the state. By the 1970s, approximately one-quarter of First Nations and one-third of Non-Status and Métis children were within the foster care system (Kirmayer, Tait and Simpson, 2009). Today we are experiencing the millennium scoop (Sinclair, cited in Lavelle and Poole, 2009). In other words, Aboriginal children are disproportionately represented within the child welfare system (NCCAH, n.d.). Blackstock (2005) points to the unsettling fact that there are now three times the number of Aboriginal children in care than those who attended residential schools at their height. She states: "First Nations children are not more likely to be reported to child welfare for abuse – it is neglect fueled by poverty, poor housing, substance misuse that drives so many First Nations children into foster care" (Trocmé, Knoke & Blackstock, cited in Blackstock, 2010). These facts become significant in this section as many of the women have been impacted by their negative experiences with child and welfare services as children and teens.

Colonial policies, based on patriarchal and racist systems, have had different implications for Aboriginal women. By way of the imposition of these systems, Aboriginal women witnessed an internal displacement from their long-held political, social and spiritual positions and responsibilities within their own communities (NWAC, 2007a; Amnesty International, 2009). More recently, in 1985 thousands of First Nations women and their children were reinstated as Status Indians under amendments to the Indian Act (Bill C-31) (NWAC, 2007b). *Bill C-3: An Act to promote gender equity in Indian registration by responding to the Court of Appeal for British Columbia decision in McIvor v. Canada (Registrar of Indian and Northern Affairs)*, which proposes further amendments to the Indian Act seeks to

address some of the additional lingering gender inequalities in Indian Registration. It is currently before the Standing Committee on Aboriginal Affairs and Northern Development (INAC, 2010).

Today, Aboriginal women are recognized as one of the poorest segments of the Canadian population (Wilson and Macdonald, 2010). Amnesty International (2009) states that Aboriginal women experience elevated levels of violence, five times that to their non-Aboriginal women counterparts aged 25-44. Aboriginal women's lower health status and life expectancy are directly linked to poverty and violence and their lack of access to basic services – such as safe housing and drinking water. And a staggering 30% of all federally incarcerated women are First Nations, Inuit or Métis. The report goes on to state that up to 80% of the imprisoned women "report a history of abuse prior to their conviction". Finally, as of March 31, 2010, the Native Women's Association of Canada had documented a total of 582 known missing and murdered Aboriginal women and girls as part of their Sisters In Spirit Initiative.

Clearly there are intersecting challenges faced by Aboriginal women. In her report on downtown eastside Vancouver Aboriginal women, Culhane (2009) sums up the intersectionality of Aboriginal women's marginalization as "the realities of everyday life in which Aboriginality, female gender, racism, sexism and poverty are lived and experienced simultaneously, not sequentially". All of these pieces help to frame the stories of the women we now turn to.

Women's reflections and narratives on childhood, teen and adulthood experiences

One of the objectives of this project was to understand the underlying factors influencing the mental health of Aboriginal women. As part of this process, women were asked to reflect upon their childhood and teenage years, as well as their current experiences. Questions related to their family life growing up, including the circumstances of leaving home, violence and substance abuse, and whether they would rate their early years as positive or negative etc. From these discussions, a number of common threads were revealed across their personal stories, including:

- Childhood sexual abuse

- Child protection services

- Racism/discrimination and conflicts around identity

- Inter-generational impacts of residential school

The following section will look at each of these overarching themes that are based on the narratives provided by the women. While specific and individual data were recorded from the 17 one-on-one interviews and will be drawn upon below,

quotations included throughout this section, and the remainder of the report come from discussions with all 46 participants.

Framing childhood/teen experiences

A number of issues arose for women when talking about their childhood and teen years. These included distress in the home, violence, substance abuse, sexual abuse, foster care placements and poverty. Over half of the seventeen women indicated that their mental health issues began in their childhood or teen years. Fifteen of seventeen voiced experiences of abuse and/or violence in childhood or teen years, inflicted by a parent, family member, foster care provider or boyfriend(s). This category included participants' witnessing abuse and/or violence inflicted against siblings, family members or within the larger community. Ten of the women had experienced sexual abuse in childhood and teen years, inflicted by family members, extended family members and/or undisclosed adults.

10 of the women experienced the foster care system, with 7 indicating that they had been placed in multiple care settings. One participant, who was 18 at the time of the interview, was still a ward of Child and Family Services. Nine women left home prior to turning 18; of these nine, five had been taken into foster care.

14 of 17 women indicated that they had witnessed substance abuse by a parent or other family members in childhood or teen years. Eleven said they had used alcohol or drugs – three in childhood, eight in their teens – with five continuing to use drugs or alcohol into adulthood. In all, nine women, or over half, believed that their childhood/teen years had been more negative than positive. Nine also indicated that their mental health issues had begun during these early years.

Child sexual abuse

A large number of women disclosed having experienced some form of sexual abuse in their childhood or teen years, both in individual interviews and through focus group discussions. While specificities around sexual abuse were not pursued in the discussions, the women did speak of the memory of sexual abuse as leaving deep imprints on their mental health over the years that followed.

According to one participant, the constant sexual abuse by her brother and father's friend, from age seven until she was fourteen, "really screwed my mind." Now in her forties, she remains unable to forget about these events and continues to struggle with violent outbursts and substance abuse. Until our interview, she had never spoken openly about her sexual abuse.

Multiple incidents of sexual abuse and violence created profound feelings of shame, embarrassment and low self-esteem for another woman. As a young person, they affected her ability to cultivate friendships; to this day, she struggles both with her relationships and with depression:

The way I lost my virginity was not of my choice, you know… being gang raped. Oh, a lot of stuff in-between. Which was sick, you know. So I have very, very low self-esteem. I think that started even before the sexual abuse. That's why I didn't make friends and stuff. I was so embarrassed, ashamed. I didn't think I was worthy of friends, didn't think I was good enough.

One participant shared her story of the sexual advances and abuse she endured by her mother's boyfriends. In order to avoid the abuse, she left home at an early age and went in and out of foster care, eventually dropping out of high school and drifting between friends' homes and living on the street. Sexual abuse at a very early age derailed her childhood and teen years. She has now been diagnosed with depression:

I ended up just staying away [from home] and trying to survive and be an adult myself, at a young age, not knowing exactly what I was supposed to be doing. I was just too focused on survival. I wasn't focused on education, which I needed in order to survive. But I didn't know that: I was trying to figure out 'Where is the next place I'm gonna sleep? Where's the next food gonna come from?', you know?

Many of the women have had to suffer sexual abuse in silence. Some of them spoke of the normalization of sexual abuse, where even they themselves as children thought it was okay. As one woman states: "I just accepted it: that's the way things were. I thought that was okay. I thought that's just the way people are." Yet she was secretly being "passed around" between her extended family members (male and female) for years. When she disclosed the abuse to her parents, they denied it was happening and told her not to speak about it. According to them, "It should be kept in the family," left for them to deal with. In fact, it took many more years before her mother and father dealt with the abuse. She believes that was because of the shame they felt: "It made them feel like they weren't good parents. … So there's a lot of guilt for them there." This woman continues to struggle with her past and has since been diagnosed with post-traumatic stress disorder.

Another woman spoke of long-term physical and sexual abuse at the hands of her brother: "He used to beat me up like I was his girlfriend. He used to treat me like I was his girlfriend, not like a little sister." Similar to other stories, the abuse occurred in secret:

I had to be in the house like at 7:30, every day when it was still daylight. I had to go to bed at 8:00 and mom would always be gone to bingo and that's when the molestation occurred. Like, [my brother] always gave her money to go to bingo and she would go and just left me at home with him. It's like they knew what was going on but they just, like, wanted to hide it; like, just leave it behind closed doors [or] whatever 'til when I brought it out.

She explains that her home community, which was the site of her abuse continues to see high rates of sexual abuse. Despite this situation, the rule is "what happens in

the community, stays in the community" and "nobody talks about it." She has since been diagnosed with depression as a result of her childhood sexual abuse.

Another interviewee whose sexual abuse began as a baby came out of it adamant that raising awareness around such abuse must begin early. For her, these violations constitute, in and of themselves, a mental disorder, one that cannot be normalized, condoned or continued in silence:

> *I had to teach my children, as far as I'm concerned, way too early. There's nothing wrong with teaching them their bodies. I had to teach them, I had to give them words about sexual abuse. 'Cause I was sexually abused from the time I was a baby 'til I was thirteen. And I didn't want that for my children. So I had to educate them early on. And it's in my family. They could [sexually abuse] what babies they want to: that's mental disorder, you know? They didn't see that as wrong?*

In a similar vein, other women shared their criticisms of the practice of excusing or explaining away childhood sexual abuse. For one participant in particular, she cautioned against continually blaming abusive behaviours on residential schools. She warns of the constant threat and potential for child sexual abuse, and is emphatic that perpetrators be held accountable for their actions, despite their own histories of being abused:

> *And the easy answer is, "Ah, it's residential school." And they brush it off to that, you know? I've heard that. That's no excuse to continue on. To me, it's just an excuse. When a person doesn't say, "Yes, I did that, and I'm really sorry," and, you know, "This is why it happened," or, "I didn't mean it," or, "I didn't know," at least to talk about it? But [instead] to see them walk around in the community in the way they are, like nothing happened, it scares me. I've told my son, 'Treat everybody with respect, but don't let them into your lives, into your family's life.' Or, 'Don't leave your children around them.'*

Child protection services

> *I was in and out of foster homes,*
> *shuffled from one home to another and then*
> *back to my biological mother growing up.*
>
> — Interviewee

Child protections services[1] were a part of 10 out of the 17 women's life stories. Of those, 7 have been placed in multiple foster homes throughout their childhood/teen years, and 4 were separated from their siblings while in care. While not every story involved abuse or negative memories, these early years of family separation and

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[1] The women used foster care, child and family services, children's aid, and CFS interchangeably when referring to child protection services.

loneliness had lasting effects on these women's mental health. One identified her time in the foster care system as an underlying factor behind her mental illness:

> *I couldn't shake the fact that I was a foster child. I had that foster child identity well into my twenties. And [it was] maybe halfway through my thirties [when] I finally discarded that identity. I just had really bad effects from accepting the label of being a foster child. [It was] one of the major things that I had a big struggle with.*

The following story illustrates the long-term impacts of having grown up in care. A woman adopted into a non-Aboriginal family as a child experienced sexual abuse at the hands of her adoptive brother from age seven through twelve. The abuse, once disclosed, was utterly denied by his mother. Eventually the interviewee was removed from the family and placed in a series of foster homes, none of which she feels was a good environment for her. She is currently living in a group home and continues to struggle with the same issues of belonging, poor self-esteem and trust. In her opinion, children in care are nothing but money in the pockets of foster families and group homes:

> *My teenage years were really a mess because I really needed parents and I was in the foster system. I was lost in the system. I was stuck in a foster home where… they didn't care about me, they didn't know my life. I was money to them. The abuse that I went through with my adoptive mother, who passed away several years ago, is still affecting me to this day. It affects everything about me. It affects how I think of myself. It affects my self-esteem, my attitude, how I view the world, how I trust, how I don't trust.*

Another woman's story illustrates the distress attached to being a child living with the panic of family separation: "That's what it was when I was a kid, 'Oh, CFS is coming.' You'd take off because [CFS] would come and take you away from your families." For her, CFS was synonymous with abuse, separation from her siblings, and being a child with no rights. It was equated with feeling "helpless and scared." Over the years, she repeatedly ran away from her foster homes and often landed herself in even worse situations.

> *They separated all of us into different homes and then I'd maybe meet up with my brother in one home and then in another one my little sister, until I demanded, like, 'Why can't we be, the three of us, be together?' And they said 'no.' Then I started bouncing from group home to group home, 'cause I would just take off from those homes. Then they would punish me…*

She has little positive to add to her experiences of being placed in group homes while a ward of CFS.

> *I hated it. … [I]t was like group homes for girls and stuff, and there would be like bullies and lesbians trying to, you know, do this and that with you. It was not good. That's why I'd run away from them. Like, every single one they put me in, I ran. Like, they put me in six, I think. … [A]nd then I was in lock up, and that*

was not good. I stopped running away then. But yeah, it was no good. I don't have no positive experience with them.

In reflecting upon these multiple placements and separations from her family, she understands now that her mental wellness has been rocked by these experiences. She spoke of regressing into that scared little girl "trying to protect her little brother and her little sister… It's not a good feeling 'cause it just makes me sad." This continues to be the mental space she reverts to when confronted by upsetting or volatile situations.

One woman expressed how being placed in a foster home filled her with fear and loneliness, equivalent to the first time leaving home. One of the participants stated that she was "treated like a slave by the white people. I just found it was hard growing up in the system with Children's Aid. It's hard to grow up through that system especially when you don't have your family." She too resisted her foster home placements:

I always ran away, but I always ended back there. I've been in [one lock-up] three times. I've been in the youth centre a couple of times. A few times I've been in [another lock-up] for three weeks and I broke out of there and I never went back. I think CFS just finally gave up on me when I was fifteen because they couldn't handle me. I guess to them I was an out of control teenager. … [A]nd I'm the kind of person that doesn't listen to anybody. I do my best now to try and listen. … I try to take those experiences and share them with other people at times.

Here again, although this participant loathed her experiences in care, she holds strong to the hope that her life story can teach and help others going through the same struggles.

So far, the stories we have heard come from women who have fought and fled the system. But for one interviewee, 'aging out' of foster care left her with a transition she did not feel ready for. As a result, at 17, she tried to kill herself using a gun:

I think the reason why I ended up shooting myself was I didn't want to live in the white world and 'cause I'm also gay and I grew up in a strict Mennonite home where that wasn't acceptable at all. And I was struggling, I think, to find my spot in life. … When you're turning 18 and you're in Social Services and they just kick you out the door, and that's it — no skills, no life skills, nothing — it was scary. I'd always been taken care of, you know, even though I didn't have a family. The money was always there. I always had school. All that came to an end for me, so it was very hard. I think that's why I ended up trying to take my life. And then surviving, which was amazing in itself.

Not every CFS experience was negative. In some cases, women spoke of foster homes as an opportunity for cultural education and promotion. One participant shared a story of how she and her siblings had been moved between multiple foster homes, many times separated from one another. While the majority of her time in

care can be characterized as negative, one of the happiest times of her life was being in the care of a particular Aboriginal couple. She expressed deep respect and admiration for the couple as they took in all of the children of her family together and "they got us introduced into the Aboriginal culture, dancing and everything." Amidst a multitude of bad experiences with foster homes, that positive time of sibling togetherness had a "huge influence" on her.

Sadly, the children were separated yet again, and were abruptly moved to different homes. When asked the reason given for the removal, she stated: "Children's Aid didn't give us no answers, and maybe they felt at the time they didn't need to answer to us 'cause we were children." For her, being a child — more specifically, an Aboriginal child in care — meant she had no rights: "Being native, we didn't feel as important."

Amazingly, despite the abuses she and her siblings went through in different foster homes, she is still able to see the positive side: "Because I've had the opportunity of living with so many different people, different cultures, you know? And I thought that was pretty amazing, you know, their beliefs and stuff; I guess I learnt a lot that way." Ultimately, her foster care story ended in her running away from home after home, being placed in lockdown facilities and eventually surviving on the streets:

> *Because, in the midst of that, before meeting my kids' dad and in-between, like, the running away from group homes, the peer group that I got involved with were street kids, you know? They sheltered me. I got involved with alcohol, I slept wherever we partied. I started shoplifting to get a change of clothes. You know, just to survive.*

Aboriginal children continue to be over-represented in child protection services. According to NCCAH (n.d.), over-representation of Aboriginal children in care has gone on now for four decades. A startling fact is that proportionately speaking, there are three times more Aboriginal children in foster care now than there were at the peak of the residential schools (Gough et al. 2005).

Shuffled between family, foster and group homes, the women in this study told of how they see their own children caught up in the same cycle they were, a fact that caused them considerable pain and shame. In a personal interview with academic Caroline Tait, she pointed out that "Aboriginal women carry a huge amount of guilt around their children, particularly women who had their children apprehended. So it's not just their involvement with CFS, it's how they internalize that for themselves." Deep feelings of grief, guilt and loss were also amongst the findings of Bennett's 2009 study which looked at Aboriginal women's experiences with Child Welfare in Manitoba (Bennett, 2009).

Based on their own histories with CFS as young people, many women make it their goal to keep their children out of that system. One woman spoke to her loneliness growing up in foster care and how she felt thrown away by her biological mother. Now a mother herself, she vows that she will be present in her daughter's life:

I want to be a parent. And I don't want [her] part of the system. My mom gave me up. I grew up in the system. I know how it is, you know? I know how it feels, and it's pretty lonely. I love my mom to death but the way she threw me away and never came to visit me, never gave me any hope to come home or anything, was pretty brutal. It messed with my head even more and made me do a lot more dangerous things to myself and to other people.

Other women spoke to their goal of getting their children out of the system and becoming a parent to them:

I'm working to get [my son] back, then I work on getting my seven year old daughter back. The mistakes that I made with my two oldest ones, I don't want to make those mistakes with my two younger ones. I want to get my kids, the two younger ones, out of the system. Hopefully, I want to be a parent to them. My kids are my lifeline.

As noted, there have been cases where women have had positive outcomes with CFS. In one case, a CFS worker actively supported a mother in her search for appropriate counseling, which was followed by the return of her children. She described the CFS employee as "a real excellent worker: she loved Aboriginal people." With her daughters out of the system, the mother herself was helped "into programs that would deal with my depression and everything 'cause I tried to commit suicide like eight, nine times."

Racism, discrimination and identity

Racism, discrimination and identity conflicts had touched the lives of virtually all interviewees. In many cases, these issues were inter-connected and intertwined, affecting the women both externally and internally. More specifically, they influenced how these women saw themselves in relation to others and how they went about seeking help for their mental health.

Memories around the first taste of racism go far back for some of the women, mostly to their childhood and adolescent years. Significantly, they remember these moments vividly. The following story from one woman told of the first time she felt being Aboriginal was equated with being 'bad.' She relates a "difficult" incident dating back to grade seven:

I can still picture him to this day, you know, blond hair, blue eyes, heavy set. He used to tease me [making remarks about welfare and natives and Main Street]... and I didn't even know anything about Main Street, you know, 'cause I had been raised in foster homes at this time, kept kind of, like, safe...

One of the women relayed her story of being singled out in junior high school as a success story amongst the other Aboriginal students. While one might think such praise would instill a sense of pride in her achievements, it had precisely the opposite effect:

I became really aware of it in junior high because it was really noticeable who the native kids were at my school. I was always picked for the school newsletter and superintendent picnic and things like that because I was a smart native girl: 'You're so smart for a native girl,' 'You're so pretty for a native girl,' 'You're so thin for a native girl." Things like that. People saying 'despite' — despite this, despite that, despite where you grew up, despite your mother...

The condescending, racist spotlight placed on her at an early age for her success triggered all sorts of issues and conflicts related to her identity, mainly "embarrassment." All her life, she has been bombarded with messaging about 'what it means' to be Aboriginal: "I've been so separated from everything, from my culture... I've only seen stereotypes, that's it."

Because she has been labeled "different" for such supposedly uncharacteristic traits as intelligence, this woman still questions what it is to be an 'authentic' Aboriginal person. Messages received at school, from the media, and at home have created confusion for her around her own Aboriginality.

I know that a lot of my ideas about what it means to be native are really skewed by the fact that I did grow up in a really stereotypical native house: the bad kind, right, the one you see on every native drama on APTN. And even with my dad, [he] tells me, 'Never date a native guy 'cause they'll hurt you and they'll beat you.' Just being separate, totally separated from my race.

Adding her mental illness into the mix, the confusion around identity grew exponentially. In particular, her continuing struggle with an eating disorder, which has her feeling she has conformed to Aboriginal stereotypes. She does not see identity as an issue for other girls with eating disorders:

Eating disorders are generally seen as like the spoiled middle, upper-middle class white girl disease, right? And I was, I'm the only Native person I've seen in an eating disorder institution in my, three or four years that I've been going to them. And, yeah, I feel really ashamed I think to be Native sometimes 'cause I have to apologize for everything: for being a fuck up in a way that I think a lot of the girls in treatment never have had to.

Internalized racism was brought up by several women. Here, one woman speaks of the first time she realized that she was Aboriginal. Due to the stereotypes in effect then and now, she has never felt pride in her identity:

When I was in Grade 5, there was one Native girl in my class and I made fun of her. I called her 'little Indian' all the time and I laughed at her... my mom said to me, 'You know, you shouldn't make fun of her.' And I said, "Why not, she's an Indian.' And she said, 'So are you.' And I cried and cried. I was horrified. I didn't want to be an Indian. And to this day, I'm not proud to be. I'm not proud to be Native.

Stereotypes and racism meted out by Aboriginal people can result in internalized inferiority, shame, identity crisis, low self-esteem, and self-hatred. Tait spoke of how a recent suicide by a 16 year old Saskatoon girl dramatically illustrates the extreme pain of racism felt by Aboriginal women and men: "[She] took her life because of racism… it's what she said, because she couldn't handle it anymore. That's really serious."

Meanwhile, other women speak to how racism and discrimination have pushed them to overachieve; in essence, to overcompensate for being Aboriginal. In part, this conduct can be seen as yet another manifestation of low-self esteem and internalized feelings of inferiority:

> *I think the positive effect was that I always strived to do more; the negative being that I had to 'prove' myself and work twice as hard to be in the same spot … as they were in, run twice as fast to be in the same spot. So, it was difficult. I put a lot of pressure on myself that way, because I wanted to succeed. I wanted to be as good as anybody else, so there's a lot of motivation for me to rise above where I came from.*

The women spoke of struggles with their multiple identities: Aboriginal, urban, English-only speaker, mother, former foster care child, mentally ill. One woman found it hard to cope with all the inter-connected pressures of being a Métis woman, her confusion over what it means to be Métis, others' racism, and the added challenge of a mental illness:

> *Being judged because of being Aboriginal, I also went through life thinking like I didn't know where I fit in: being Métis this way, that way, you know, I was just all over the place. Then, like, just for someone who is just struggling and being Aboriginal and then to put that depression in there, too… Oh my god, it's just overwhelming.*

Some have equated being Aboriginal with an internal struggle. They've needed to mediate between their cultural upbringing and the dominant Western worldview. The following quote comes from a woman who moved to Saskatoon in her early twenties after a childhood spent on her reserve:

> *I was raised to be a Cree woman. But at the same time, there's another worldview just attacking my Indigenous worldview, [that] kept telling me it's wrong, it's wrong, it's bad or it's stupid. So that's … the white I'm talking about. I was always fighting … just to be okay as an Aboriginal woman.*

Tait concisely refers to this as an issue of "citizenship", meaning that identity is infused with internalized and externalized struggles around "Aboriginality". She puts forward the following statement:

> *Citizenship is a huge issue. I think we see citizenship in terms of the Métis people who have lost their identity. As a Métis person, they know they are Métis but they struggle to try to find a sense of community. Citizenship in the sense*

that Aboriginal people are constantly told that they are not full citizens of Saskatchewan – that they are burdens of society and because they have their special status that no one else has. There's a real resentment against that status because people don't understand it. That all becomes internalized played out in terms of what people feel about themselves. And I think it then translates inter-generationally with people.

Just as racism and discrimination have affected Aboriginal women, many also spoke to the intergenerational effects of residential schools which we will now turn our attention to.

Residential schools

Residential schools have had a lasting effect across the generations. de Leeuw, Greenwood and Cameron (2009) emphatically state that "residential schooling is now understood as an important contributor to the health disparities lived by Indigenous people across the country." Instituted for over a century, Aboriginal children first entered residential schools in the late 1880s. The last school closed in 1996 (AHF, n.d.). These schools deliberately separated Aboriginal children from their families and communities, in many cases for consecutive years at a time. They were established to "re-educate" Aboriginal children through a policy of cultural, linguistic and religious assimilation. The physical, mental, emotional, and sexual abuses that took place within these schools have become well-documented (Milloy, 1999; Kirmayer, Tait and Simpson, 2009). Children returned to their homes after their schooling unable to relate to their families culturally or linguistically. The family and community bonds were severely ruptured.

Through discussions with the women throughout this project, many referred to an understanding that their lives had, in one way or another, been impacted by these schools. A great number of the women spoke primarily of their own mothers' lack of emotional displays, or coldness, towards them. They have come to see through the years that their mothers, who had attended residential schools, were never shown affection or emotional comfort in those environments. When they became parents, they themselves did not have these skills to draw upon.

- *My mother was a product of the residential school system. My mother didn't know how to respond to us. She couldn't hug; she didn't tell you that she loved you because she wasn't taught that as a child. [W]e didn't grow up [feeling] that she loved us, or showing any kind of affection. I definitely blame it on the residential school system because she didn't have her family in a nurturing environment. So when she became a mother, she didn't raise us in a [nurturing] environment either, because she didn't have that to fall back on. It's definitely the residential schools.*

- *My mom was raised in those schools and there was no emotional bonding. Like I was never allowed to cry, I was never allowed to express my feelings. My mom just last year told me she loved me. Not once when I was young,*

when I was little did she ever tell me she loved me. Until like last year and it shocked the shit out of me. I thought are you okay? Are you sick? Am I ever going to see you again? Well all this stuff is going through my mind you know and now that I know that she was in those residential schools, it's like I can understand now but before I was like "why are you so mean to me?"

- *I am three generations who never had to go [to residential school] but to this day I find my mother extraordinarily cold and that comes from [her] being told not to have feelings.*

Through her training program to become a counsellor, one interviewee spoke to her realization that the dysfunction in her household was based on the abuse experienced by both of her parents in residential school. They simply never learned how to be parents, when as children they themselves were abused by those who were given the responsibility of raising and educating them. In turn, the generations that followed have never learned to be parents. She stated, "I learned in counseling they didn't know how to parent. And now, we don't. We've learned a few things because we were lucky we stayed a family, and we weren't taken away like a lot of people were, but it was still dysfunctional because when they came out of school, we had to deal with all their abuse too."

Another woman highlights the insidious cycle of childhood sexual abuse. While she did not attend residential school, her abusers did. While they were interned, they also experienced sexual abuse, "these uncles I'm telling you about? Their abusers were from residential school...I found out later that they were sexually abused by each other."

Another woman talked about her childhood and identity as having been severely affected by colonization and the affects of residential schools. She states:

I didn't understand what I was going through as a child. I wasn't really taught the values and morals of the family unit. And I think that came from colonization, and residential schools because they take who you are as a human being as an Anishinabe, Blackfoot, Cree - you have rules in your community, and as a woman, or as a man. And as a child you're taught what is proper and what to stand for, and I wasn't taught values and morals. So I grew up guessing how to live on my own. And so I've been abused – physically, sexually, mentally, emotionally – so I have all those factors in my life and I was trying to live proper, to the best of my knowledge. And some cases I didn't do so well, and I really internalized a lot of things with myself. I self-blamed myself, I self-hated myself.

Given the experiences of the women, it would appear that more data needs to be collected to understand the fuller picture of how the impacts of the residential schools have jumped from generation to generation. For instance, what are the health outcomes, including mental health outcomes, for the generations who were parented by residential school survivors?

In sum, as will be alluded to in other sections of this paper, an important part of healing begins with understanding that the individual and collective histories experienced by Aboriginal women factor into their mental well-being.

While the intention of this study was not to make empirical correlations between life events and adulthood experiences with mental illness(es), the women clearly articulated their own assessments of the lifelong impacts stemming from being powerless and vulnerable in early years.

Lifelong experiences, such as having experienced physical, sexual, emotional or mental abuse in childhood, or being passed from foster home to foster home, have shaped the mental health of the women involved in this project. In addition, their identities have been affected by everyday discrimination and racism rooted in colonization and ongoing colonial policies and practices.

This paper will now turn to how the women define their mental health and how they are experiencing mental health - including stigma, and coping strategies.

SECTION 3

ABORIGINAL WOMEN'S PERSPECTIVES ON MENTAL HEALTH

Defining mental health

Depending who you ask, mental health may be defined and understood in a variety of ways. For example, the Mental Health Commission of Canada (2009) states that mental health is not merely the absence of mental illness. The Commission goes on to state that "mental health problems and illnesses are believed to result from a complex interaction among social, economic, psychological and biological or genetic factors" (ibid).

Within the draft Strategic Action Plan for First Nations and Inuit Mental Wellness, mental health is the "lifelong journey to achieve wellness and balance of body, mind and spirit" (First Nations and Inuit Mental Wellness Advisory Committee, 2007). It also includes: "self-esteem, personal dignity, cultural identity and connectedness in the presence of a harmonious physical, emotional, mental and spiritual wellness." Accordingly, mental wellness must "be defined in terms of the values and beliefs of Inuit and First Nations people." As part of an Inuit-specific piece to this mental wellness action plan, the Inuit Tapiriit Kanatami (ITK, 2007) view mental health as impacted by the broader social determinants of health[2].

As part of this project, Dr. Caroline Tait, a Métis woman from MacDowall, Saskatchewan, assistant professor (Native Studies and Women and Gender Studies, University of Saskatchewan) and member of the Indigenous Peoples' Health Research Centre (IPHRC), was interviewed. Based on her long-standing research in the field of Aboriginal women and mental health she has come to see a "continuum of mental illness, mental distress and mental wellness — where people flow back and forth" (personal interview, February 3, 2010). She also recognizes that there are different ways of looking at mental illness. On the one hand, there are the "set of illnesses that are physiologically-based and which interface with what is happening with someone's body physiologically and the brain." On the other hand, there are the periods of "mental distress" that people may experience at different points in their lives.

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[2] Social determinants of health include: income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture. Indigenous social determinants broaden these to include: colonization, globalization, migration, cultural continuity, access, territory, poverty, and self-determination.

The Elder participants spoke to their cultural understandings of mental health as including trust, caring and belonging. When "there is a lack of caring, that is when other things breakdown". They spoke of people with mental illness as important members of the community. One of them translated the Cree word *kaya-nitawapih* which was used to mean "don't laugh at them [referring to the mentally ill], the Creator has a purpose for them and loves them very much".

When the women who took part in this research project were asked how they would define mental health, they spoke of happiness, lightness, stability, healing, safety, peace and a feeling of balance in the mind, body and emotions as characteristics of mental wellness. Here is some of what they said, in their own words:

- Happiness: just being happy. I just want to be happy, but not the dumb happy. Not the happy you get by giving up, I guess. By just giving in, giving up. I want just to be stably happy, just happy.

- I mean, like, if your spirit's broken, it's broken: what can you do? Mental health and well-being would be a spirit that's not broken, I guess. Intact.

- To me, it means trying to heal yourself. Trying to heal your mind of all the experiences that you've been through and trying to focus on positive things.

- Emotional and psychological well-being.

- All my life it's been a constant struggle trying to survive and be happy. I'm trying. I'm tired. I'd like peace of mind.

- Not sad and depressed. You don't feel like killing yourself. You don't want to drink. You don't want to do drugs or go fight someone.

- I feel light, physically lighter. The light seems brighter. I am more ambitious to do things, to try things.

- Stable. Stable with yourself and your family. For me, because I'm bi-polar, it means that I'm able to function, and that I'm not on my down side of my bi-polar. So I'm not hiding and sleeping. So being healthy and functional, and an active parent, 'cause that's so important for me. When I'm in the down part of my illness, I'm not functional, and that just really bothers me.

- Peace of mind. Yeah, because my mind gets kind of rushed all the time, you know? I'm always one step ahead of myself. I have to actually learn, try to train myself to be in the moment, in my body.

- I think it's inherent in the philosophies of Indian people's beliefs and teachings on Creation: the fostering of the body, of mind and emotions. Neglect one, it affects all. So, it's holistic.

- It means being in balance and feeling it.

Alternatively, mental illness, as defined by several of the women, can be seen as a state of loneliness, a lack of control and being lopsided:

- Being sad and lonely. Alone.

- It's just the past experiences that we've allowed to go out of control.

- I don't know what 'mentally well' means at all.

- I think when you don't feel safe to be yourself, you're not mentally well. Because if you're not safe to be who you are, and to live the way you want to live, and love who you want to love, then your whole world is upside down and sideways; and nothing looks right until you're able to stand on your own two feet and be who you are and live the way that you want to live because then everything else in your world is a lie.

Self-assessed mental health

For the majority of the women, their mental health has been largely influenced by an accumulation of life experiences. Likewise, their current mental well-being is influenced by the programs, care and support they've received from family members and the community.

Again, speaking directly of the seventeen one-on-one interviews, while some had been diagnosed with one mental illness, others were found to have multiple disorders. In one case, a participant suffered from depression, bi-polar disorder and seasonal affective disorder. The seven undiagnosed women spoke of issues around anger, anxiety, depression and eating disorders. Only one woman was unable to name her mental illness. All of the women indicated that they have been or continue to be concerned about their mental health.

Regardless of any specific diagnosis, all of the women shared concerns about the state of their mental health. For some, the realization that they had a mental illness was not immediately clear to them. They may have been struggling with substance abuse for a period of time to numb their feelings of depression from past trauma, but they did not define this as a symptom of larger mental health issues. This is consistent with research on mental health and addictions (Hebert and McCannell, 1997; Bohn, 2003; Chansonneuve, 2007).

For one woman, the realization that she was suffering from mental health issues became apparent after watching a commercial on television. Although she has since realized that her issues began in childhood due to sexual abuse and being within the foster care system, she only realized the outcomes of these experiences in adulthood:

> *And I wasn't aware you know, because, like, even on those commercials they show a woman just not taking care of herself hygiene-wise, and just, you know, baggy clothes, pajamas, you know, that was me, that was me, clear picture of*

me. And I just thought, 'Oh my God, I put my family through that,' you know? But I always tell them, 'I didn't wake up one day and just say, just give me depression.' And I didn't wake up one day and say, 'Make me an alcohol and drug addict,' you know. I could wish and wish all those things away, but I have to accept them. They're a part of me, you know, but it's what I'm going to do with it and how I'm going to cope with it, that's the key thing. And for a long time I was in denial of everything, you know, and I didn't want to hear it from anybody.

Other women said that their mental illness just appeared one day for no particular reason. The following woman speaks of "bad medicine," which is, for her, the only explanation as to why she went from being mentally well one day to mentally ill the next.

It just happened one day, and I just got really sick and I couldn't sleep. There was times I couldn't sleep and it had me, I was up, like, for days I guess and it was, like, in my head. There was like somebody running around and I could hear things ... I couldn't sleep. I was scared to sleep.

For some of the women, mental health issues have been a constant throughout their lives. They cannot recall a time when they did not feel deep sadness, loneliness, depression or anxiety. They also understood how these symptoms played out on a day to day level. For example, one woman, diagnosed with clinical depression, struggles daily to get out of bed and face the world. She spoke of a constant need to hold thoughts of suicide at bay. While psychiatrists pin her mental illness on the "factors in her life," she understood her mental health as rooted more deeply in a lifelong discomfort "in her own skin," like she was "lost" and didn't know who she was or where she belonged. While surrounded by a loving family growing up, she remembers being very sad and not loving herself:

All my life I've been feeling like that. There's days when I just feel empty, I have no enthusiasm, no outlook or anything else, you know? Just what do I have to get up for? I just don't even care. I don't even want to get up. I just want to stay asleep so I don't have to be anybody, you know. I just think I am somebody, you know, but if there's billions of people around, what am I here for? If I'm gone, nobody's gonna notice. It's basically how I felt ... pretty much all my life, I guess.

Another woman noted that her mental illness has always been in her life. "For as long as I can remember: that there's nothing for me in the world. I have no point, no purpose, no destination. I've always felt like that ever since I was a kid." She relayed how her struggle with anxiety and depression is largely based on the neglect she faced as a child. Even though she grew up with her biological family, the needs and issues around her other sibling always came first.

I always felt overlooked as a child. When I was in grade nine, I had a thirty-five average in at least half of my classes and my parents didn't even look at my report cards. When they came in to parent-teacher half-way through the year,

the teacher goes, 'You realize your daughter's failing. You realize that she's probably gonna have to repeat this year?' And they said to the teacher, in front of me, 'Well, no. No, she's fine. I'm not worried.' And my whole life, my whole relationship with my parents, has been like that. I'm the one they don't worry about because everybody else is crazy. They get the attention. What about me?

Then there is neglect experienced by women once they entered into the mental health services and programs. A woman who sought help from some health professionals felt they neglected to equip her with a full, clear and comprehensive explanation of her mental condition and why her condition was happening to her. Instead, she was simply sent off with medication.

When I first came into my mental illness, I didn't really recognize it. I didn't understand it fully. I wasn't really taught about it. They just gave me medication and said, 'This is what it is.' They're very straight-up and very professional. They don't go into details except, 'Well, you have hallucinations.' They didn't explain it enough to me.

This woman has since conducted her own independent research in order to gain a deeper understanding of her condition, which was a common practice amongst other participants who had been in and out of the mental health services and programs for many years. Perhaps as a result of their long term struggle with seeking help, some of the women became very well versed in understanding their mental health and symptoms:

My mental health, I don't feel it's the best. It's kind of tenuous. I've also been diagnosed with borderline personality disorder, so one of the biggest, I guess, symptoms of that is emotional disregulation, my mood. I have really bad mood swings. So, I'm super sensitive to things people say. It's terrible. I don't think it's very good. I have stopped being actively suicidal, so I think that's a plus. I have tried to commit suicide twice, once when I was sixteen, once when I was seventeen, but right now I think I'm still sort of functioning. I'm trying to try.

There are also situations where, despite the diagnosis, women are not convinced they have a mental illness *per se.* Instead, they distinguish between mental illnesses based on chemical imbalances in the brain versus emotional/mental conditions rooted in life circumstances. Being lost in the foster care system, experiencing childhood sexual abuse by a sibling and mental abuse by an adoptive mother, being denied help when she spoke of these abuses, and currently struggling to get some basic assistance with her life, this woman has been exposed to multiple distress throughout her life. Although now grown up, she continues to feel trapped in the pain of her childhood. For her, it is logical (not biological) that her emotional and mental state would be imbalanced. Again this woman shows in depth knowledge of her mental health:

When I was about 19 I believe, I was diagnosed with bipolar and it's something that I strongly disagree with, because bipolar refers to having mood swings and

my mood is always low to suicidal. Bipolar refers to people having manic episodes and being over the top, having energy, and I never, ever experienced that. I never had a manic episode, so I don't understand where they get the bipolar. I know that I have a mental illness but whether it's a chemical thing, I would argue with that, because anybody who had lived my life, knew my circumstances, would have a mental illness. It doesn't mean it's chemical, it means it's circumstantial. I've been through a rough life and if that's a mental illness, then I guess I have a mental illness. … I've been through some stuff that no pill is ever going to fix.

She goes on to say:

When you have emotional problems, and you go through abuse and sexual and mental and physical abuses as a child, when you become 18 years old… you are not an adult, you are still a child. That's what nobody understands about me. I may be 29 years old but I'm still a 7 year old girl who is crying to the world because I got put back into a home that I have never should have been put in. … I'm not an adult, I'm a child but I am expected to be an adult and think like an adult and perform like an adult but … I'm still that little girl that didn't get the love, that didn't get the attention and didn't get what I needed.

Coping with their mental health

The women were asked to describe the strategies they use for self-care – what they do to take care of their mental well-being. It was noted by one participant that coping is a part of a lifetime healing journey and requires patience and "taking baby steps." Women were employing a wide array of personal and collective coping strategies. A number of women spoke to self-medication as a means of coping with traumatic life events. These linkages are consistent with findings within mental health research to date (Bohn, 2003; AHF, 2007; Herbert and McCannell, 1997). Within this study, the women identified other strategies they have used for self-care and coping and include:

- Physical activity

- Being in nature

- Taking care of animals

- Literature, studies and philosophy

- Escapism through media

- Puzzles and games

- Ad hoc support networks

- Staying busy

- Participation in community programs

- Religion and prayer

- Cultural practices and celebrations

- Counseling/therapy

- Medications

Some of the women described the freedom they experienced through physical movement. Exercise, while helping their physical health, was also effective as a means to soothe and calm them. They also spoke of self-care, through escapism through various media and in keeping the mind creative and busy through reading, study and doing puzzles.

- *I'm still quite athletic. Me and my bike: that's my favorite. When I'm on my bike, no one can touch me. I really like that space 'cause it's just me and the wind and my bike.*

- *I love going on bike rides. I love going on my computer. I learn. I used to love to read. I used to eat books, practically … but for the past few years I've just lacked the concentration to do it. I love going on the Internet: it's escapism.*

- *I read a lot. I cope by school. I really threw myself in my studies, so I lived in my mind all my life. I'm a thinker, a philosopher, I guess. I try to eat a well-balanced meal. I try to exercise. I say I do, but I know I don't exercise enough. I like aqua-fitness. That's what helps, 'cause I like that floating sensation.*

- *I read a lot of books: that's my new escape from reality. I won't use drugs because it will kill me but it won't kill me to read a book and I don't have to talk to anybody and I don't have to think about my screwed up situation that I can't seem to fix. When I read a book, I just focus on what that person is going through and it takes me away. I watch a lot of TV and I eat a lot of chocolate.*

- *Right now I watch this program, 'Joyce Meyer.' She was a lady who was sexually abused by her father for 15 years and is now a minister on TV. She talks about her experiences and how people pretend to be someone they're not. She's just a really frank lady. I really appreciate what she has to share. I listen to her every morning while I do my exercises or have breakfast. And I also watch 'Tribal Trails.' I like watching Aboriginal people and how they dealt with things. It is gospel related.*

- *I do math puzzles 'cause it makes me feel better about myself, 'cause if I can struggle through that puzzle and complete it, it gives me… [a] feeling of accomplishment.*

Being charged with the responsibility of caring for a personal pet was an aspect of one woman's coping. In fact, at times, she views her cat as having saved her from self-harming behaviours:

> *When you take care of a pet you're taking care of something, someone needs you, like something needs you. When I moved out, I got a cat and it just made me so happy. Sometimes it was literally the only thing that kept me from hurting myself: 'Oh, I can't do that — I have no one to feed my cat if I need to go to the hospital.'*

Being in, and feeling connected to, nature was a strategy employed by another woman. She also remembers coming up with her own ways of taking out her frustrations:

> *I was in therapy. I feel connected when I'm outside. It doesn't matter if it's wintertime or it's snowing, you know: I could find beauty in nature and I nourish that in myself. My therapy … was dealing with the anger and using a punching bag or having a tennis racket and beating up the couch. Ah, couch cushions. That felt really good because it was releasing it.*

Women actively create and seek collective spaces of safety and comfort. These are even more important for women who would otherwise not be able to leave their homes, for whatever reason. In this example, the women involved in this ad hoc support system are suffering from disabilities and mental health issues:

> - *There's three of us. We call each other. We all live with the same issues and when we don't hear from each other for at least a week, a week and a half, then we start calling, even if we talk for two minutes just to say, 'Are you okay? Do you need anything? What's going on?' So, in that sense, we need to support those kind of networks and groups, and there's nothing really for us, you know? You have to have that strength to want to go out there and look for stuff. And sometimes you just don't have it.*
>
> - *My best friend, her and I, we get together once in a while. I see her whenever I need to. She encourages me and I encourage her. We are both somewhat still struggling, in some form or another. We call each other a lot.*

Still in this vein, another way that women coped was through involvement in community activities, helping others and surrounding themselves with positive and supportive company. Several women spoke to the need to move forward and to do this they must leave behind the negative people and situations that did not serve their health in earlier years. For some of the women, being busy, through work and community service, gave them a larger purpose:

> - *Going to [the community training centre] was just a blessing in disguise you know and being accepted in there and then just the women in there, a lot of us have experienced a lot of the same shit and we're all survivors, we're all strong*

Aboriginal women. And now we're going to be out there and we're going to be helping families and hopefully young youth and pick out their strengths and that's my coping.

- *I started drinking when I was thirteen. I've done a lot of drugs, I did T's and R's, crack cocaine, pills, acid, LSD. Now I'm trying to heal myself. I'm trying to heal myself through my journey to do positive things. My [boyfriend] and the other relationships that I've had have made me the person that I am today, and that's a very strong woman that's been through a lot of shit. I've been through so much crap that you could never put me back there again, and it's time to move forward.*

- *I volunteer at [a community centre] right now. We cook there. Last week I was there helping with the flu clinic. Helping the old people. ... [W]e cook and we feed people that come from the outside, like the homeless people.*

- *I think women my age, they'd like to get into stuff that they could do. Like even one time, I volunteered at the school, and then I ended up enjoying it. With the kids. Find stuff to keep me busy. To feel good about myself, doing something.*

- *I'm just taking my medication and just being busy and trying to put my head in order.*

Taking care of the spiritual side, women use cultural practices, celebrations and religion for self-care. Speaking to Elders and praying help the women face their challenges as do strong relationships with family members.

- *Smudging, prayer, a strong relationship with my mom.*

- *I used traditional healing. I've went to sweats. I've spoken to Elders. I stayed away from negative people and try to look forward.*

- *I smudge. I call my mom. I go to Sweats. I go to pow-wows.*

- *I go to a lot of ceremonies. When I'm really in a bad place, a dark place where I can't get out, when I can't handle something on my own, I'll go to a Sweat Lodge. I'll meditate. Or we'll do a Pipe Ceremony.*

- *For myself, I have to continually talk about my addiction. I go for tests and document it and try to pay attention to the symptoms of relapses coming on and stuff like that. I smudge because I've got these cravings. I talk to Elders. And one Elder, I try to talk to him on a daily basis 'cause it helps me.*

- *Right now, I pray and I read the bible and I go to church. And that's what I'm hanging on to right now. My religion, that's the only thing, more than the meds.*

As alluded to earlier, some of the women spoke to self-medication as their primary means of coping.

- *Sleep — well, it's not really sleep. No, actually, lately I've been more self-medicating: pills and stuff like that nowadays, where it was crack and alcohol before, and I find my mental health sometimes is diminishing.*

- *Eighteen years ago, I lost my two kids and the only way I got them back was I had to get counselling for what happened to me. I know that was a poor excuse, like saying that that's why I did drugs … but when I was high on the drugs then I'd just ease the pain, you know? I just forgot about everything.*

- *I just put everything behind me and try to anyway and if, if I drink and then it comes out and I don't know and not thinking straight and I end up fighting.*

- *I go fight somebody. I know that's not the answer, but I go try to talk to somebody. If I can't talk to nobody, I go drink.*

- *I just go for a walk or I'll have a cigarette. Like, I don't smoke much but when I'm stressed one cigarette will be good, 'cause it calms me down. I don't like being alone, 'cause then, you know, I'll start thinking about [the stress] … 'Oh, maybe I'll just go get a six-pack and, you know, drink it and go to sleep.' And it's panicky: I don't like feeling that way … so I'll smoke a joint and it will go away…*

Understanding that mental wellness and healing is a journey — requiring time, energy and a re-learning of how form to relationships and simply be within the world — a front-line worker working on issues of trauma at an Aboriginal women's centre in Winnipeg succinctly brings together many of the coping methods discussed so far:

> *Well, they've coped with prostitution. They've coped with drugs. They've coped with alcohol. There's some that have coped with self-mutilation. Taking pills. Now, here, when they come, you know there's still that struggle with the drugs and alcohol. But they reach out: we have an addictions worker here, we have a trauma worker here. We have a couple of the counselors that are here, so they reach out. They're learning how to cope by reaching out, that it's okay. They seem to be more comfortable talking to an Aboriginal worker. We have a gym downstairs, they're learning how to utilize that. They do a lot of writing, they use this [healing] room. The medicine, the traditional medicines are in here. We have actually a compulsive coping program which teaches them positive ways of coping. So they're learning, there's tools.*

Among the 12 women who had been prescribed medication for their mental health, there were differing opinions about their net benefits. Some believed they assisted their overall ability to cope with mental illness, while others experienced conflicts, both personally and externally, over their use (see Section 4).

Traditional medications were used by some of the women with positive outcomes. One woman recalled being in an institution for her mental illness and being approached there by one of its Aboriginal workers. He invited her to take part in a

sweat-lodge ceremony instead of her prescribed pills. For her, participating in that ceremony had the effect of having her sickness taken away.

> *After being in that treatment centre, I felt good and I was taking my pills like three times a day. I was taking them when I was in my first week there and this [man], he's looking at me, and he says, 'You know what, they're having a sweat this evening, why don't you go for a sweat.' I heard about these sweats. Like, it was hot, and I really don't like being hot, and I says no. And he said, 'You know what, to tell you the truth, you see these pills? ... These pills are white man pills... these are what make us sick in the beginning... You go for this [sweat-lodge] ... you won't even need these pills." I was in that sweat all evening ... and I came out of the sweat about 11, I think. All evening I was in there. I woke up just good; like, when I came out of that sweat, I just felt brand new. Like, I didn't feel sick. It's like that's what took all the sickness away.*

The Elders spoke of the need to respect both Western and Traditional approaches to healing, and self-care including the use of prescription pills, when necessary, combined with ceremonies, when requested. One of the Elders stated the following:

> *If they are coming to you in order to get that traditional perspective and intervention, yes, it is very important. Aboriginal people get doctored in many ways, they go elsewhere and then come back to traditional methods, so they do it combination with the medical ways. I myself, sometimes I am called to hospitals to go smudge. They need that as well as they need the doctor. It's a different way to do things. And thank God that now we are able to do things in the hospital.*

In sum, Aboriginal women define and understand mental health according to their lived experiences. They also utilize numerous and varied strategies for self-care. From this point we now turn our attention to their voiced barriers to healing and recovery.

SECTION 4

BARRIERS TO "KNOWING MIND *FULLNESS*"

*Whether seeking mental health services or seeking addiction services
women are very pragmatic about what they are going to do. If it means
they will lose their jobs or if it means that they could lose their housing
or lose their children or lose their relationship, all those things will play into how the
woman makes the decision. That's what worries me a lot.
It's not that they are making bad decisions where they don't seek out treatment and
services, but often what it was is they are making pragmatic decisions in a context
where there are not a lot of great options. (Caroline Tait, personal interview)*

In this part of the study, we aimed to understand the challenges preventing
Aboriginal women from seeking help with their mental health. All of the women
were at unique points in their journey toward wellness. While some had never
received help, others were veterans of the mental health services and programs,
having made multiple attempts at accessing different programs and services.
Despite the diversity of mental health issues presented by the women and their
distinct places on the continuum of care, they collectively identified a variety of
common barriers to seeking the care they required. The following barriers were
identified by the women:

- ❖ Anonymity
- ❖ Confidentiality and trust
- ❖ Inter-personal relationships
- ❖ Fear of losing children
- ❖ Lack of childcare within mental health programming
- ❖ Cookie-cutter approaches
- ❖ Lack of cultural awareness and training of mental health care workers
- ❖ Fear of institutionalized care settings
- ❖ Misdirected focus of mental health programs
- ❖ Process: waiting lists, diagnosis and referrals
- ❖ Lack of validation
- ❖ Distribution, usability and access to mental health information
- ❖ Racism
- ❖ Physical disabilities
- ❖ Side-effects of medication, over-medication and the wrong medication
- ❖ Stigma

Anonymity

> I was too ashamed and I didn't want nobody to know about me and my past and what happened to me. They might no like me after they know that and I won't have no friends or nothing. I hate to be rejected.

Being part of a community can lead to many positive outcomes for Aboriginal women. They may know their neighbours and their neighbours may know them. They may be familiar with community workers or they themselves may work in the community. Their immediate and extended family members may also be well established and known within the community. Yet such familiarity and social networks can also present a variety of barriers to Aboriginal women seeking community-based help with their mental health. For Aboriginal women well known within their communities, getting such help therefore may not always be a simple process.

While some spoke of being unaware of the programs and services within the community, others actively avoided them. In the case of the former, one woman voiced a lack of knowledge of "where to go or what to do" to get help regarding her mental illness. Her internalized shame and stigma around her abuse and mental illness pushed her to seek services outside of her North End Winnipeg community so she could preserve her anonymity. Her refusal to entrust her story amongst community members and support workers was based on a fear of losing friends, being rejected, or becoming the source of gossip or ridicule. Scared of being labeled "crazy" or even worse by support workers who might "phone and put me in a place or something," her fears demonstrated how community can become a barrier to Aboriginal women thinking of accessing local programming.

Confidentiality and trust

> I'd like to go to more groups, but you know, I have a fear of who is going to be in there and who is going to talk about me after. Because some of it is so sensitive.

Again, while the community is a good starting point for accessing programs and services, there are issues around trust and gossip, which hinder women's ability to openly disclose their stories. When women are familiar faces in the community, quite often the family members who may have perpetrated violence and abuse are too. As noted by one woman critical of group therapy settings (*e.g.*, talking circles or sharing circles), they may be sources of comfort, safety and commonality to some, but to others they can be unsafe spaces, provoking anxiety over disclosing personal stories and linkages to family members.

There are other reasons why trust is hard to come by. One that was talked about involved the constant turnover of health professionals. Here, a woman speaks about

how difficult it is to trust a therapist, since she never knows when that therapist will leave.

> *I finally trust a good therapist and now she comes and tells me that, 'Oh, I can't do this with you for years and years, and you have to go to [so and so]. You have to make that transition again to trust someone. It's too bad 'cause it seems like you just have to move all over. And it's hard to trust just one person, never mind three or four.*

Inter-personal relationships

Family support would make a lot of difference. I would have felt more supported, more loved, more accepted, more understanding within myself.

While most participants identified family support and understanding as central to their mental well-being, a number of them stated that family members had directly or indirectly served as barriers to their mental health needs. Recall that of the 17 women interviewed, ten had been physically or sexually abused by family members.   Among them, a woman who spoke out against the horror of years of sexual abuse by her brother; he threatened to retaliate and "kill [their] mom." It was only after he had committed suicide and the loss of her children to CFS that she sought counseling for her deep depression.

When seeking accountability for child sexual abuse, women spoke to the multitude of barriers placed before them. There is family denial, silencing of the victim, defending the actions of the perpetrator, and blaming the victim as a "trouble maker" for speaking out. One participant had these insights into how this silencing only compounds a victim's mental distress:

> *I've tried to seek accountability from my own family members, and… [was told] I was going to be hurting my mother. So I thought, 'I'll wait till after she passes away for these law cases." And basically, what I was told is, if I sought accountability, I was a troublemaker. And that it would look bad beyond the family. So a lot of times we're told not to be accountable because it's going to affect other people. It doesn't allow us to seek our justice. So in that sense, we can't have peace of mind because everything is still hidden. Everything is 'Don't talk about it.' So you still have to find balance with your mental health. You have to be believed, and you have to have accountability. And when we're trying to do our own healing, we're being accountable for our emotions, our actions, our health. But yet, the abusers and the people that have been living their lives like they did nothing wrong are getting away with it.*

Another participant remembered the constant verbal and emotional abuse she received from her mother. Although her mental health was being talked about by many professionals throughout her life, ultimately, her mother denied her daughter the help she needed.:

The problem is no one really helped me when I was growing up. … My mother denied… that I had an eating disorder. She was constantly trying to convince me that I was crazy. She's had doctors, the school doctor, the school nurse, the people from CFS, saying, 'There's something wrong with your daughter,' and nothing was really done.

Another participant recalled negative experiences with her mother. She also talked about how her attempts as a 14 year old to get help through therapy were effectively thwarted by her mother:

[M]y mom came with me to every single session. And, I'd be there talking to the doctor and, in the middle of every single session, she would burst into tears, interrupt, and go, 'Oh, but I try so hard, I try so hard. I don't want my little girl upset and depressed, and I don't know what to do. And she's not happy and I'm trying to give her everything that she can possibly need.' It wasn't about me. … It was six months of me making my mother cry. So how is that supposed to help me at all?

Nine years after this initial experience with counseling, she continues to struggle with her mental illness, and the relationship with her mother remains tenuous.

For other women, their spouses or partners did not try to understand what they were going through. As a result, some spoke to the breakdown of their relationships or lack of support they received.

… you know I think that's, that contributed to our breakup of my marriage because of the lack of communication and understanding. He never took the time out to truly understand what depression was about or get information about it to be supportive you know.

Negative effects on spouses and partners due to women's mental health issues were also identified; in some cases, the relationships had completely disintegrated as a result. As a means to protect her partner from further anxiety and potentially keep the relationship intact, one participant chose only to selectively disclose aspects of her mental condition to her partner:

I tell him if I've lost time. I don't tell him for how long. I tell him if I'm having impulses. I don't tell him what they are. Because he's had to be there when I'm having seizures, he has to be there if I'm having my depression on the weekend and then I can't get out of bed. I don't want to 'cause him any more stress, because he's told me that I've been giving him a lot of anxiety.

One woman spoke of discord within her foster family due to their misunderstanding and denial of her mental illness. Her foster mother, instead of equipping herself with knowledge around depression, responded to its symptoms (such as over-sleeping and emotional spikes) by telling her to "stop feeling sorry" for herself.

The theme of denial re-occurred across various accounts of unsupportive families. However, in two cases, things went beyond denial. For one woman, speaking out about her abuse saw her sister accuse her of "lying" because she "just wanted attention. … A lot of times we're not believed." Another participant faced a mother who essentially silenced her through the fear of labeling.

> *My mother always made it a big deal, 'You don't want to look weak or that you have mental health issues in any regard whatsoever,' because then you'll be tainted. You'll never work, so that scares you. Then you can't talk to them about it because they don't want to hear about it. They don't even acknowledge that that's real.*

Not having family members, friends or community to call upon exacerbates the isolation and loneliness — and mental distress — experienced by women. One participant told of how she has been left to take sole responsibility for her mental health. She feels uncared for by the social and health professionals who are supposed to be helping her. For her own well-being, she has needed to remove herself from an unsupportive and dysfunctional family environment. She does not know where she belongs within the larger community: "Just even friends or something, someone who wasn't paid by the government [to talk to], that would be awesome." All of these issues add up to her not receiving the supports she needs to find mental wellness.

> *And they [therapists] are telling me to take personal responsibility, but it's so different for people who have family and friends and people around them … because you have people monitoring you … and not even just people monitoring you, but people who care about your actual well being. In CFS, it's social workers and support workers and people just wanting to know your weight. And if your weight is okay, then you're okay. Or, they just ask 'Are you okay?' And by 'Are you okay?' they mean, "Are you going to kill yourself tonight?" And if you say 'No,' or, if you say, 'Yeah, I'm okay,' it's fine. Like, I seriously wish sometimes they'd just ask me if I was going to hurt myself, because asking me if I'm okay is just such a crock of shit because no, I'm never okay. I'm never okay. But I'm not going to hurt myself tonight, so I guess I'm okay. Just really wish that would change because I can't magically have a family, or magically have friends to take care of me. I'm trying really hard but that's why people are in therapy because they can't do it on their own.*

Non-supportive environments — including households, extended family members, communities and organizations — can have negative impacts on a woman's ability to realize the help she needs. Lack of family and community awareness of mental health in general also strips women of their voicing their mental health issues and concerns. Instead, it raises barriers of stigma and labeling.

Fear of losing children

Several women spoke to the fear of losing their children if they disclosed their mental health illnesses. For women struggling with mental health issues, CFS is perceived as a huge barrier to their seeking medical help. The risk of losing children to the system outweighs their mental well-being. These stories are important to hear and understand. If community organizations and agencies are to better serve the mental health needs of Aboriginal women, the multiple barriers, including policies around the removal of children from their mothers must be addressed differently.

- *You can't ask for help. You go to the doctor and say you don't feel well, you're not feeling right, 'I'm not feeling like I can deal with the children' … next thing you know, someone's coming to get your children. You're afraid to say anything 'cause it can go another way, and that's a big risk. 'Am I gonna get help or is it gonna get worse?' So you just end up not saying anything about it.*

- *I think it's a common underlying thing that if we disclose, the first thing they do is to take our kids. I've been faced with that three times. And not even trying to understand what I was going through — that's the instant cure for women like us, is take our children. I don't like telling people what kind of pills I'm on, but then I got to a point where I don't give a shit now. Because I'm surviving, and I have to be on these pills just to live and cope and function, and I feel much better about it. But two years ago, I would never disclose what kind of pills I was taking. … Because right away someone's looking at you like you're an addict. … And when I was a single mother that was the thing right away, 'Well, you're single now. I'm gonna take your son.' Pretty much, you know? I've seen it. … I think it's a reality for many of us Aboriginal women.*

- *Because people are on pills, they get their kids taken away, because their disability is taking over them. They can't handle it because they're bipolar. I'm not bipolar but I've seen it happen so many times. So, of course, people get scared… And talking to my doctor without getting reported … I'm an honest person when it comes to my health. But to be so scared to lose someone you love so much, you know? I'd rather just keep it inside, and cry at home. And when I go out, put on my makeup, and put on my phony smile. Because it's very hard.*

Frontline workers recognize that lack of trust is a real barrier to women seeking help for their mental health, particularly if there are other issues rolled into the mix.

> *The ladies are willing to come in here, but going beyond here to the health services or even down to [a family service], they're really nervous about because there's a lack of trust. There's a huge lack of trust. If they talk to somebody else, then they're going to report them to family services. They're already involved with family services, and they have things going on with their children and a huge fear that their children [will be apprehended] because there's addiction issues involved and the family issues are involved and the*

parents issues are involved and addiction services and all these other issues involved around their life because of mental health and everything else going on with them. And so how do I tell everybody else, who can I tell? Where do I go?

The women are critical of a system which frustrates their ability to parent, not only through a lack of support for their parenting, but by removing their children. As one woman aptly put it, "They don't come help *me* help my children," a sentiment echoed elsewhere:

They don't go in and try to help the mother, give her support to look after her children. Support her! Not, 'We're gonna take your kid, then you go get help.' We should be able to have services in our home. Where people come in and [say], 'Let's work together to see how we can help you be a better mother in your home.' Not out there somewhere, where we have to leave our home. You know it's tough and it is a fear.

Lack of childcare within mental health programming

The lack of childcare is another important barrier that was identified by the women concerning mental health programming. In Saskatchewan for example, "There are no services where women can take their children with them." A front-line worker in Saskatoon criticized a centre specializing in mental health which does not take into consideration the childcare and transportation needs of women, has long waiting lists and whose mandate does not provide mental health services off-site. She states:

Probably the biggest barrier, the one place where the people have told me that they have had difficulty, is going to the [centre] to see a psychiatrist. There's no place where you have child care there. They don't like that you taking your children with you to appointments. It's difficult to get there when you're going there by bus because you have to get off and walk so far. And the psychiatrists don't come out. A lot of women just won't go and I don't blame them to be honest with you. They have to wait a whole year. It's not that psychiatrists don't care, it's just that's where they are and they're not mandated to come out of their clinic. It's not a mobile clinic, so they don't have to come out so they won't.

Cookie-cutter approaches

What soon became apparent through discussions with Aboriginal women is that no one program, be it culturally or western-based, will suit the needs of everyone. Given differences of language, socio-economic status, education, cultural beliefs, religious practices, among others — Aboriginal women are by no means a homogenous group — it therefore follows that programs should not follow a 'one-size-fits-all' approach. The women clearly voiced the need to have a variety of services, therapies and programs to choose from. This way, they would not be stuck having to follow a healing journey tailored to someone else's needs.

Several women shared their perspectives regarding the talking circle format, commonly employed as a 'culturally appropriate' component of Aboriginal programs. One woman refused to access the local women's healing circle due to her shyness and anxiety around having to "talk in front of everybody." Acknowledging that other women thrived within this counseling format, this particular woman found that even stating her name in this kind of group setting proved "just too much" to handle. Unaware of any other one-to-one counseling that she could obtain within her community, she was thus unable to make use of the community-based supports available to her.

Another participant regarded the talking circle as an acceptable approach to healing, but was unable to fully participate because "it just seems like I can't focus on myself. It just seems too selfish or something." And another woman spoke about this format of sharing -among other healing programs- as not providing her with the profound therapy she needed. She then sought out alternative therapies:

> *I did the women's circle. I went to this family healing lodge, and we did a women's group there for a couple years. And we did a lot of smudging there, eh? That was good. But it was a pool, where I just kept swimming in around and round in circles, in the garbage. But I didn't want to be in there anymore. I wanted to be out of it, if that makes sense. I wanted to be done with that, and that's how she [therapist] helped me, and what she did was Rapid Eye Movement, it's REM. Those alternate ways of working through the abuse for the memories.*

To take another example, one woman complained of how journaling (a required part of the program she was taking) proved difficult, onerous and exclusionary for participants, particularly for those with lower literacy levels. Simply put, for the women involved, programs need to make sense to the users or they will quickly become a barrier to women looking for support and help in their healing process.

Lack of cultural awareness and training of mental health care workers

Some of the women identified gaps in seeking help from non-Aboriginal mental health workers. For one woman, although she has enjoyed working with her therapists, she understands that: "a lot of them aren't culturally aware. They don't have no connection to the residential [schools] or whatever, the 60's scoop, or even Child and Family Services. I think there's a gap."

Women stated that there is the need for cultural awareness amongst mental health workers which includes an understanding of the historical and contemporary components to knowing Aboriginal people. There is also a deeper piece around cultural competency and safety. One of the women stated the following:

> *Like I said, I went to a Caucasian counselor and I feel like I didn't get much out of it but I did try to find something out of it. I think they kind of miss the mark*

because the lack of understanding… [of] what makes us tick and what are the expectations placed on us as women. We're a community: we think as a community. We're a part of the group. That's what I was part of, and where I could give in some capacity because we are like that.

These ideas ring true in the words of another woman who recognizes that, for Aboriginal women, there is a fear and discomfort in speaking about their experiences with a non-Aboriginal therapist: "It's frickin' sad, especially for the Aboriginal women that are very uncomfortable talking to Caucasians. That is so scary. Oh, my heart goes out to them, 'cause I know a lot of women like that, it's a trust issue, hey."

Fear of institutionalized care settings

Labeling and stigma feed into the fear of being "carried away in a straitjacket" and constitute another barrier. One woman was once afraid that "they would put me in the psych ward" if she sought the help she needed.

Feelings of entrapment, fear, loneliness and a general lack of support by the health professionals characterize the experiences of the women when speaking of their experiences within institutionalized care settings.

One woman recalls her time in a psychiatry ward of mental health centre. The environment, in and of itself, was not appealing or soothing to her; as she did not understand what was happening to herself or others within this setting, it instilled fear in her:

> *[T]hat was a dreary place to be … I remember the things they do to people in there, and it was like scary what they did to people. It's like they were using these people like guinea pigs… [for] new drugs. It seemed like, I don't know, maybe it was just my mind but, I don't know, I'd see some of these people freaking out and they'd go shoot them with something else.*

In a similar experience at the same mental health centre, another woman was in the lock down facility and found herself triggered by the people and the setting more than anything. She recounts how patients were left primarily on their own:

> *I felt a little bit trapped. … The only people that I felt somewhat comfortable with was the patients, but some of them disturbed me because they reminded me of past issues of other people. There's no interaction with, really, the workers and the patients, so it's mostly patients to patients. The only time they would interact is if there was a dispute or a fight between patients.*

This same woman was also admitted to a Winnipeg hospital for a period. While this institutional setting provided more activities and encouragement by staff, she explained that information was hard to come by:

[T]hey weren't too bad. They always made sure that you got up and do activities. You're so bummed out that you don't want to, but they try and encourage you. They had more leisure time for the patients at the [centre]. But they're so busy that it's hard to get information. For example, like to do with [Social Assistance], it was hard to get the social workers' time, because they weren't there as often.

Another woman was highly critical about her current care home setting. According to her, this home is recognized as one of the best in the city of her residence. But she claimed "if this is best, there's a problem." She continues to experience profound frustration over how it is run. To date, she has experienced a lack of positive care, empathy and support by the two home care workers. After having lived much of her life in different foster care settings, to her this is another living situation where she is made to feel "stress and rejection and hurt and anger and resentment." Despite paying for this service, in her view she has received nothing more than one good meal a day. She is emphatic that she signed up for much more than this and is exhausted in trying to seek the help she desperately needs.

There's no support there. … They are getting a paycheck doing nothing. There's a problem with mental health homes that are getting extravagant amount of money. $2,000 a person a month and all they are giving is a meal. We need more than that. I'm not in a home to get a meal. I'm in a home to get emotional, mental [help]. I need love, I need support … I don't have the best hygiene but I need encouragement. I need someone to throw a party for me when I take a shower, not yell at me that I'm taking too much water.

It is important to hear and appreciate the range of experiences Aboriginal women are having within institutional and home care settings. Are they receiving the support they need? Are they being informed about what is happening within the care centre? Are these centres improving their mental health? There is good reason to be critical of mental health care services, as it can lead to better outcomes. It is fair to be frustrated with services and programs that are not meeting the needs of their clients. The woman in the case above makes a valid point for the need to evaluate mental health care settings and their workers.

People need to have a freakin' clue, and not be allowed to run a care home just for the money. It makes me sick … that is abuse. Abusing people with mental illness to put money in your pocket. … I feel like I'm a nuisance in that house. They just want to shove me in the basement, in the corner, and say, 'Go live your life.' That's not what I came here for. I came here for help. And so far, I've not gotten any help.

Misdirected focus of mental health programs

> **I think there has to be more different avenues for people to pursue. Not everybody fits into the same block. You can't put round pegs into square holes and we're not all round pegs. So I think things have to be personalized for each person, the programs need to be personalized**.

Women also spoke of cycling in and out of the same program. In the case of one participant suffering from a long-term eating disorder, her critical lens identified the use of outdated therapies, undertrained or under-skilled therapists and severely underfunded programs. According to her, programming for adolescents with eating disorders is a "joke." One suggestion she put forth was the need for therapists and programming to focus on the person, as opposed to the illness. Here again, the usefulness and effectiveness of programming stems from meeting the particular needs of clients. In her best estimation, it made no sense to call upon a group of malnourished, starving girls with long-standing eating disorders, to participate in overly vigorous activities. She noted that one must have been teetering near death by starvation in order to receive care or be hospitalized for her specific mental health disorder.

A front-line worker based out of Saskatoon affirms the need for programs to look at each woman holistically. Questions need to refocus from targeting the mental illness to looking at all that is going on in her life.

> *I don't feel [programs] are adequate. They're not working to meet the woman's needs, in a holistic way. They're treating the chemical issue, but they're not treating the woman. If they really want to deal with the issue, then they need to start looking at the woman and her life. Otherwise, she's going to be non-compliant, and then nothing's going to happen, nothing's going to change. And so if you want her to be compliant, you need to help her deal with everything else that's going on in her life - her physical health, education, addiction, family – all the stuff that's going on. If you don't do that, then you can always harp, you can harp, you can harp, you can bring her back in, you can bring her back in, and get other agencies involved, and you're gonna have too many agencies involved. You're just gonna be over-servicing her and overlapping services and the big issues are still going to be there.*

Process: waiting lists, diagnosis and referrals

The process required before receiving mental health services, including lengthy waiting lists for referrals to a psychologist or psychiatrist, can be onerous. The women who took part in this study made it clear that the process is, in and of itself, a barrier. They spoke to the extreme levels — including suicide attempts — they each had to demonstrate in order to finally get the attention they needed.

There were a significant number of women who had over a number of years tried repeatedly to access mental health services and programs. In one situation, a woman had been living with an undiagnosed mental health disorder since childhood. Since that time, she has sought help through a variety of avenues; however, she is constantly up against the process barrier. She is doing what she is supposed to do for her mental health, which is to seek the support available to her. Sadly, even with good knowledge of how the mental health system works, knowledge developed as a patient, she was exasperated by the inability of the system to serve her needs:

> *I have a copy of the [city] mental health guide, and I've contacted a lot of those agencies, and I get sent this little survey that I'm supposed to complete and send it back to them. And six months down the road, I might have an appointment. SoI kind of gave up.*

If there was more places for them to go to, so that they don't have to wait on a waiting lists for six, seven months, 'cause that could be very discouraging for people.

Declaring herself incapable of going at it alone with her mental disorder, she has confronted multiple barriers throughout her lengthy involvement with the mental health services and programs. At base, she feels invisible within the system. Her frustration also lies in the fact that mental health workers link her illness to alcohol use and that her need for support and a straightforward diagnosis has fallen on a long line of deaf ears. In her own words:

> *I'm trying to get in to see a psychiatrist or psychologist — I don't know what the difference is right now — in order to find out why I'm hearing voices and getting impulses, 'cause it's driving me crazy. It's been going on for a really long time and it's always, 'Oh, here's a waiting list.'*

She is not alone in her frustration. One participant went so far as to attempt suicide, knowing that it was the one way that she could bypass the waiting lists and get some much needed help:

> *The second time I [did it], I don't feel like it was actually a suicide attempt. It was a gesture. The first time I was like, 'Yeah, let's die,' but the second time it was because I was on the waiting list for the program and I just couldn't take it anymore.*

She was not the only participant who brought up suicide as a perversely 'necessary evil' to dealing with process. Certainly, others highlighted the absurdity of the length of time it took just to be referred to someone to speak with about their "down days." Referrals and waiting lists pose a barrier to meeting the daily mental health needs of women. Clearly, they should not need to be on the edge of suicide to gain access to support services. Nor should women have to worry about the costs associated with getting help: for those living in poverty or on limited budgets, the cost of therapy

alone could exclude them from these services. One participant spoke directly to her mental health needs and the barriers blocking the help she needed:

> *I have been telling people and telling people and telling people I need therapy. The problem is, nobody is going to pay for it and I have to go on a waiting list; even when I can manage somehow, I still haven't figured out how to get on a waiting list for therapy. Who's going to pay for it and when am I actually going to get to the top of that list? When I'm making a $134 a month and I'm a smoker, do I have money to pay a therapist $100 a session? ... Even if I can see a therapist, I could not afford it. How am I supposed to move forward when I know what I need but I can't access it and I can't pay for it?*

It is not only those women looking for mental health services who bemoan the barriers presented by process; front line workers are also highly critical. One of them, for example, equated process with "time wasted." For this Winnipeg-based front-line worker, women get so lost in between the cracks of filling out applications, waiting to have their applications reviewed, waiting for a referral, or waiting to see a doctor that, in the end, many of them "just don't want to be bothered" any more by the process.

Lack of validation

A serious barrier highlighted by the women was not being believed, either by family members or by the mental health professionals they approached. In the following case, a woman sought help through a multitude of avenues and was continuously let down. At her most recent visit to a doctor, she was told, to her astonishment, that her mental illness was due to the use of alcohol five years prior. Now in her mid-twenties, free of drugs and alcohol, she has sought help with her mental health since the age of fourteen. It is thus unclear to her how drinking at nineteen could have anything to do with her present episodes of hallucinations, seizures, and blacking out for days at a time:

> *I've been through [clinic], for their drop-in counseling. I also got in to see a counselor there when I was in college. I saw a psychiatrist when I was 14, 17 and 19. I'm in group therapy right now. But I feel like nobody actually listens to me. I went for a psych assessment in January and saw a doctor, and because I used to drink heavily five years ago, he's come to the conclusion that the voices that I hear have to do with my alcoholism, so how is that helping me?*

Not being listened to or believed is not an uncommon phenomenon from the point of view of one front-line worker, who called it "secondary wounding." In other words, these women are now "being abused by systems" like the mental health care system, as well as by those perpetrating the original abuse.

Distribution, usability and access to mental health information

> **I feel like I'm informed. And I'm the type of person, like, I will go looking for services, and I didn't know [this centre] was here. The thing is how to get that information out to people?**

There are services and programs in both Winnipeg and Saskatoon but they are not always easy to find and access. Indeed many of the women spoke of not knowing the mental health resources in their communities despite their repeated attempts at searching them out.

One woman spoke of her frustration of having a mental health guide in hand yet feeling ill-equipped in knowing where to call to get help. Short of knowing what her specific mental health disorder is she expressed great frustration in cold-calling to the organizations listed in the guide. Add to this the lack of knowledge sharing between the different agencies and she has been left unable to find proper mental health attention.

> *In calling around to all of those places, it's a very blind process. I don't know who to ask for or what to ask for because for starters, I don't know what's wrong with me. So how am I supposed to get help if I don't know what help to ask for? And, those programs don't know anything about each other. I call and I don't even know what I say 'cause I usually just start talking and I hope that somebody is listening to me and will tell me what the hell I need to do. And they say, "Oh, we don't offer those kinds of services here. Try calling this place". [I ask] "who would I talk to there?", "Oh, I don't know". Gee thanks, you know? You might as well just open the phone book and dial some random stranger, they'd probably do a better job.*

Her frustration was again pronounced with the response she received upon calling a crisis line listed in the mental health guide. In this instance she reached out for mental health support and was mistreated by the worker who received her call. In fact, this is a clear example of secondary wounding.

> *I had gone to the [city] Exhibition and when I got home, I was having a lot of impulses. I had a lot of people in my head, and I was really upset and my boyfriend couldn't calm me down. Somebody had just given me the mental health guide and that's one of the big numbers on there. So I called and I said, "Hey, this is how I'm feeling right now. I really need somebody to talk to." And I got told, "Well maybe you just shouldn't go out in crowds." Like, "oh, wow, thanks, you know? I'll just not go to work then too. Or I won't get on a bus. That's so helpful." I told that to her, and all she had to say was, "Well you don't have to be rude".*

Clearly the services have not worked for her when she was most in need. Despite her efforts at researching and accessing the mental health information provided to her, she unfortunately convinced herself that the problem lies with her and is not a malfunction of the system. She stated: "you know what, I've caught all these people

at the wrong time, that's what the problem is."

Not all of the women have access to basic mental health information. They may not have a telephone from which they can call or receive calls from mental health organizations. While the world is now connected through the Web, not everyone has access to a computer, let alone Internet. Compound this with literacy generally and computer literacy, such as understanding search engines etc., specifically, and the barriers to mental health information become more evident. One women alludes to these barriers but also for the need to find practical solutions, such as postering of information in high traffic places:

> *Sometimes too, in areas where there's a lot of traffic, is where you find programs is through posters. That's how I found this, and some of the things that I go to, get involved with I found through posters. And so that way it works. But the average person that doesn't go out, or like, you're involved, you're out there, you know people...I've met a lot of people that just stay so isolated, and they don't have access to internet. They don't even get the paper.*

Another woman stated that now that mental health is more recognized and talked about, that there is the need for more information to be in the hands of those who need it. Again, she calls upon practical ways of getting the information out into the community. She states: "I'm thinking you should put flyers into the mailbox of the whole neighbourhood, because where do people get this information until you're coming in for services?"

Importantly another woman made reference to need to spread the word on mental health services but be aware that some of the programs have attached criteria that can again create another barrier. She states: "It comes down to the information you can access. If you do an internet search, you can find lots, but, do you qualify? Because in my case, I'm not defined as a residential school survivor, so I don't qualify [for programs]."

Of note, one of the PWHCE project team members was tasked with calling the mental health supports and services in both cities. While she recognized the large number of supports and services, in Winnipeg for example, she also observed barriers related to the criteria laid out by each program, including costs, process, and long waiting lists among others (see Appendix 6).

Racism

Racism emerged as another barrier to women accessing mental health care. In one case, a woman described her experience in seeking out help and felt that the workers were "really mean to Natives" and that they look at Aboriginal people as "just another sniffer off the street or another alcoholic off the street". In addition to her experience with blatant racism, there was a lack of counselors present, even though it was a counseling program. She stated "I don't know why the treatment centre is even open".

Physical disabilities

There were two women who participated in the study who were both living with a mental illness and a physical disability. For them, just getting out of the house, due to their physical challenges can exclude them from the available mental health programs and services. One of the women stated:

> I've seen situations too of women who are living with severe disabilities, who don't leave their homes. It would be nice to see mental health workers go in the home. For people who have mobility issues, or even just to share information, to talk, see how that person's doing. There's a lot of isolation around disability.

Side-effects from medication, over-medication, and the wrong medication

The use of medications created multiple meanings for Aboriginal women. Their experiences speak to the potential pros and cons of using medications and how the same drug may have very different effects from one person to the next. A woman's ability to view medications as a valid avenue for coping with her mental illness can become complicated when family and community deny the illness or pass judgments on western-based approaches. This confusion is compounded further by culturally-based interpretations of how Aboriginal people are to approach healing. In the end, women need to be well-informed about *all* of their potential healing options as, ultimately, it is they who must to decide for themselves the route they will take on that journey.

While some of the women were fine with the use of medications as a method of day-to-day self-care, there were others who were critical of prescription drug use, saying the mental health issues they were struggling with required more than a short term solution: the deeper soul wound required counseling and other forms of profound healing. According to one woman, prescription drugs, while serving the purpose of alleviating the symptoms of mental distress, need to be used in conjunction with other strategies:

> I believe that medication is a band-aid. It is a cover up. It is a way of making the symptoms go away but it doesn't really fix it. I mean, I don't need medication: I need therapy. I need somebody who can work with me, with my issues, and deal with the issues instead of just giving me a pill and then go away.

Women also discussed the physical side-effects from medication. One interviewee in particular has experienced a number of unwelcome side-effects without any of the intended benefits for her mental health symptoms. She therefore questioned the long-term effectiveness and use of the multiple medications she has been prescribed. At the end of the day, she must make a cost-benefit analysis: do the drugs help her enough that they are worth the short and long-term consequences?

I've been on every kind of pill there is. It doesn't help. It makes me gain weight. It gives me side effects. It gives me dry mouth. It gets me fat and everything. It doesn't help fix whatever's going on inside of me. I'm worried about this pill, and this pill, and this pill over the span of ten years. What is that gonna do to my body thirty years from now?

Another medication-related problem extended from how different pills would alter women's emotional state to the point that they felt they were different people altogether. In the following account, a woman speaks about her first experience with medication where it simply didn't work for her. Concerned over how it made her feel and how the drug stripped her of her ability to respond to the world around her, she requested a change in medication. She continues to take the other medication with positive results.

When I was diagnosed back in 2000 with depression and was put on this certain medication, it didn't work for me and I knew that, too. I believe it was Paxil, the first thing I was on. I didn't like myself on it. I knew I wasn't that person either and, like, I was just in a comatose state ... Not that I wanted to react, really, like, explode or anything, when things occurred, but I had no emotions. And that just wasn't me, 'cause I'm a very sensitive person. I knew that and I just wasn't responding to anything, you know, whether it be happy or sad. So I said, 'No, I can't take this medication." So now I've been on Effexor for a good amount of time.

Another woman who started to take anti-depressants at the age of 19 stated that the medications were always "trial and error." She too made reference to how the pills altered her state and made her feel that she was no longer herself. Regrettably, she saw her inability to find the right medication as an indication that she had somehow 'failed':

Some of the pills that they put me on really made me a different person, like, completely. And now I just... I don't even know what to do anymore, because I feel like everything's just getting worse. And it's, like, 'Oh great! Now we're just a total screw-up.'

Another woman spoke to this same experience of losing her sense of self due to prescribed medication:

They just always want to give me anti-depressants. I think that's why I just about killed myself that time, 'cause I just don't trust those things at all. And they said, 'You're gonna get worse before you get better.' And I did get worse. And now I have two people, maybe three in my family, that were on anti-depressants, and now, they're not all there either. And they're very smart people and they can't function now. I did take them. I was like a zombie. I didn't feel anything at all. And I had an awful feeling about it.

Similarly, another woman told of how she has been on different medication over the years with limited success. When one type of anti-depressant seems to work for her

initially, ultimately her depressive emotional state returns. She continues to search for the right medication that would consistently relieve her mental distress, and this endless quest, in and of itself, causes confusion and frustration for her:

> *In [my] mid-twenties is when I started falling apart again. I did start taking medications. Different medications, different anti-depressants. [I'm] still looking for one that's really working. Like, they seem to work for a while and then I guess my body just gets used to them and things go back to the way they were. The thoughts, the attitude, or the blankness. Like, there's nothing there sometimes.*

Notably, women spoke of family and community interference with their use of medications. Again, this caused them undue stress and confusion particularly since they were trying to make sense of their mental health and seek the necessary help, which for some included medications. In one case, a woman tells of how she was bombarded from all sides. Family members were discouraging the use of medication based on their own beliefs. She was made to feel that medications were bad, and so she stopped. The result was devastating, which led her to become her sole advocate for her mental health needs.

> *I had other family members who were strong and who found their way and were strong to the culture. They thought I was doing wrong by taking the medication, that I didn't need it. So I had all these people that were trying to doctor me and I was getting more confused. I ended up taking myself off my own medication cold turkey and I had a crash and I attempted suicide. And then, when I got back on my medication and stuff and there was people that were trying to direct me not to take it … I had to just tell them to kind of like silence themselves, because it's me, it's my body.*

Women also spoke to their confusion related to the use of western-based medications and traditional medicines. For example, women who have decided to take only western medicine were confronted with internal conflicts. As one participant related: "I've also been told, 'Don't take western medicine, 'cause your traditional medicine won't work.' And so that 'causes a lot of confusion for people."

Stigma

According to the Mental Health Commission of Canada, stigma "describes a negative and unfavourable attitude and causes those living with a mental illness to be labeled, stereotyped and feared[3]." Women in this project spoke to the multiple layers of stigma that they have experienced. There is externalized stigma around mental health, or that which the women experience from the outside world - be it

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[3] See Stigma: The Facts
http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2009/Stigma%20The%20Facts.pdf (last accessed March 29, 2010)

through labeling or negative behaviours expressed towards them. This is often mixed with their own internalized stigma of having a mental illness, perhaps articulated through self-hatred and low self-esteem. Beyond this, they spoke of the complicated intersections of shame with being labeled mentally ill – Aboriginal – woman – and in some cases poor, disabled, addicted and homeless.

> I believe [there's] stigma around mental health. That's why I believe there's a lot of people that go undiagnosed and a lot of people are in denial about even what's happening to them, unaware 'cause they don't want to be treated differently or called a 'looney toon' or 'crazy' you know?

For one participant, she states it like this: "there's stigma on mental illness and there's stigma on being an Indian person. So it's difficult. And there's stigma on being homeless." Stigma also prevents her from seeking a job because of her belief that the larger society will not hire a mentally ill person. In her own words, "I'm not sure like, for myself I've been trying to find employment and that's another stigma, I'm fearful of saying, 'Oh, I have mental illness'. Then I won't get employed."

Her fears are not unfounded. She related a personal story with a mental health care worker who spoke unfavorably about the misuse of funding for Aboriginal clientele:

> *I feel saddened by the fact that, like, some of us don't have mental illnesses but we're still part of that stigma as Indian people, that, [we're] the 'Indian problem'. One example, [involving a mental health care worker], she's a non-Aboriginal, she says, "Well the government is just feeding off you guys' hurt and pain". She says, "They'll just donate a bit of money to you and you'll go dwindle it off with that."*

In the case of two interviewees, they expressed that they felt "alien" or not "human". These comments highlight how labeling makes the women feel abnormal, that they do not have a place within the community and that society neither accepts nor understands them and their mental illness. This, in turn, has tremendous impacts on how they then see and feel about themselves:

- *When I go out in public, I feel like there's 'normal people' walking around, and I feel like I'm an alien walking down the sidewalk. I feel that people can look at me and say, "She has a mental illness". I feel different. I never had that attitude before. I was not going to let a mental illness affect my life, and now it affects everything. It affects the way I feel about myself on the inside.*

- *And so I have a label on me now that I fight. I have people who look at me like I'm not a human being. I'm less than everybody else because I'm mentally ill. And I fight that, I fight that every day. And it's hard to feel good about yourself as a person when you have that label on you.*

Another participant recounted the different attitudes she experiences in urban, southern environments as opposed to when she returns to her northern Aboriginal community. While in the south she experiences primarily racism, in her home community, while accepted as an Aboriginal woman, she is labeled "crazy". Again, the result is the struggle she is up against in finding support, acceptance and understanding.

> *I also have racism in the southern communities. I also have bi-polar disorder and when I'm not doing so well I get stigmatism from my own community. They label me crazy so I got it from a lot of different directions. I know that for myself, when I take on the label and the stigma – I struggle with that sometimes – and have trouble with addiction issues. And so when everything goes firing out of control, I don't know where exactly is my best support? I think a lot of my own mental health concerns the problems that I encounter and a lot of people are unaware of bi-polar disorder especially way up north. That's why they label me crazy 'cause they don't understand and they think a lot of it is B.S. I'm having a hard time with acceptance and understanding*

In the words of another woman, having been diagnosed with a mental illness had a long-lasting impact on her. The label of being "unfit" to work, or be a parent was correlated to her mental illness. In a sense, knowing that this label remains in her personal file means that she has to constantly struggle against the stigma which says that she is not 'normal', or a 'good mother'.

> *If you're bi-polar and schizophrenic and all that, once you go and get tested by a psychiatrist, and therapist, and you write down what you have, that's it. There's no going back. And you have to go to a lot of people to [get back into] that normal category, instead of having that illness, because it affects everything and everywhere you go, because it's written down in your private files. I myself being on social assistance – that's one of the things that they put on there, is that I'm unfit to work, and get a job, because of what that psychiatrist put on there. I also had to fight to keep my children, because of what the psychiatrist put on there about being unfit and I'm a good parent and I can't keep my kids. I had to win a lot of support from people that would back me up, let them know that I am a good parent, and I was able to get my kids back. But I don't want them looking back at what that psychiatrist is saying about not being a good parent, and it's kind of hard because I'm trying to go on with my life, with my kids, but that's always eating me at the back of my head. I've been trying to, I have to find that self-esteem.*

In some cases, there is a fine line between the women's own perceptions about herself and that which she feels from others around her. The result is however the same – she ultimately will struggle with not feeling good about herself or her condition.

I have the most negative attitude about myself, because of my mental health. I have quit things, really good jobs, university programs because of my drinking or because of my mental health. And so I'd see myself kind of like not really going anywhere. .I do believe that certain people that I know – they haven't told me – but my perception is that they see me as being unreliable, unstable.

Many women talked about how they themselves looked poorly upon mental illness, including their own mental health. In the following case, the interviewee spoke about rejecting a program because she would need to be seen publicly with a group of other individuals with mental illnesses. She very candidly speaks of her own stigmatization of people with mental illnesses, which in essence is based on how she has been treated as a result of having a mental illness.

They have programs, for example, bowling. But to go bowling, I'm supposed to go out in public with a bunch of people who have different levels of mental health issues. It's probably not a good attitude to have but I don't want to be seen in public with those people. I don't want to be associated with that group of people. I tend to stay away from getting involved with mental health because I don't want to be labeled. I don't want people looking at me and say, "oh she's mental." Definitely, I have a stigma about mental health. I'm just the same as everybody else. Mental health seems like we're not the same as everybody else. We're not altogether human. We don't have feelings and we don't have any kind of knowledge. I feel like we're society's rejects. They don't want anything to do with us. We can't get a job. We're not accepted in the community.

This same woman shares the following narrative which sums up the very troubling issues associated with stigma and labeling related to people with mental illness. For her, the labels that have been placed on her have effectively stripped her ability to see a future for herself.

And now, because I have this label, this mental illness, I gave up all my dreams. I gave up the dream that I would ever get married, that I was gonna have a child. I gave up the dream that I could go out and get a job like everybody else. I gave up the dream that I'm gonna own a house, a car, live my life. But all my dreams are gone. And just in a matter of months, I'm living in a decrepit environment, where you can't cook supper, you have a mental illness. And if I can't do those kinds of things, how am I ever going to get a house? How am I ever gonna get a job? I refuse to let my mental illness drag me down, but now I'm at the point where my illness has dragged me down. Because I'm at the point now where I've just kind of given up everything. I don't want anything out of life anymore, and that wasn't the case before I was diagnosed. I had the world by the tail. And I was going to go out and do a whole bunch of stuff and be on Oprah and own a house and you know, get a job and go to college and, I really want to go to university so I can get a degree. But it's in my head now all the time, "You can't go to university. You have a mental illness." And I'm like, where did that come from? Where did I get this message from, that I can't do

anything anymore? And it's because of other people putting that label on me. Constantly, constantly, constantly, and now, I'm believing it. I'm believing that I'm not a human being like everybody else. That I can't have dreams and goals and aspirations, like everybody else.

Of significance to this project, stigma has the effect of women not seeking the help they need for their mental health. As pointed out by Tait: "I would say most times, because of the stigma associated with mental illness, the stigma associated with addictions and the stigma associated with Aboriginal identity which is very, very strong in [Saskatchewan], I would say that combined are worse where women may not seek the program and services that they need."

In sum, this section highlighted the multiple, and often overlapping, barriers which have been identified by the Aboriginal women who participated in this project. Through their stories, it has become evident that their mental health needs are not being fully met by the current services and programs. In order to better address these needs, the following section will give voice to these needs alongside the programs and services which have been well-received by the women thus far.

SECTION 5

ABORIGINAL WOMEN'S MENTAL HEALTH NEEDS AND SUPPORTS: THROUGH THEIR OWN EYES, IN THEIR OWN WORDS

Our grandmothers and our sisters,
we can do this together, and
we can take our hurting sisters along
with us, and we can help heal hurt.
We can't leave them behind:
we need to take them with us,
but we cannot live in the past.

— Frontline worker

The overlapping mental health needs identified by the Aboriginal women who participated in this project essentially boiled down to three: validation/diagnosis of their illness, having someone to talk to, and help with locating suitable therapy.

It is important to remind the reader that the women each had unique and divergent perspectives on mental health services and programs. While some forms of support worked for some women, they did not work for others. In other words, it is difficult to draw out hard findings based on this project. We can however make some overarching generalizations, nuanced with the unique feedback from the participants.

The need to be heard and receive answers

Some women expressed more specific, comprehensive and immediate mental health needs, needs that stem from not being listened to and respected, and thereby ignoring their mental health questions. One woman recounts her frustration over the multiple ways she has voiced her needs without appropriate and timely action in response, a gap that has left her feeling victimized by the system. The fact that this is not happening, despite all of her efforts, has left her feeling abused by the mental health system.

> *I've been yelling all my life. I've been saying all my life, 'I need help.' Because I keep on telling people that I need help but I keep on getting slammed on my face. It's more abuse. It's not physical but it's emotional abuse. I need therapy: I don't need pills. ... I don't need a psychiatrist. I [need to] find a therapist who could go back over the [issues] with me, of abandonment, of abuse, of sexual abuse; [to] work through them.*

Feeling abused by the support workers around her, she needs to know that she will be treated equally, regardless of her mental health.

I need people who are going to support me and not just say, 'Oh, you have a mental illness. I'm not going to believe what you say because you're not in your right mind.' I've had experiences where people, like with my [caregiver], I went through a period of time where I wasn't sleeping. And I've never had a problem sleeping in my whole life. Because I have a mental illness, she disregarded what I said. She said, "It's in your head." She said, "You think you're not sleeping but you are." And I said, "What is this? Just because I have a mental illness does not mean I'm not the same as any other person in this world. I still have feelings, I still function like everybody else." I'm not taken seriously because I have a mental illness.

Similarly, another woman shared her concrete need to have answers concerning her mental illness: "I need someone to listen to me. I need someone to believe me. I need people to stop shrugging off the things that I tell them." Above all, she wants a diagnosis, a process that has been going on for over a decade, since she first sought help at age 14. After seeing numerous doctors for her "black-outs, memory lapses, time loss, all the different stupid terms they give it," she needs to know "why I'm having seizures, and, after, like, half a dozen MRIs and trips to the hospital, nobody knows why." So even though she has persistently sought medical attention, so far no one has been able to provide her with a specific diagnosis, which would at the very least allow her to better understand and cope with her mental illness.

Realize that I'm looking for answers. I need to know what's wrong with me. I need to move forward in my life. If I could put a name to it, I'd stop calling myself crazy. If I knew what was wrong with me, at least I'd have an answer, I'd have something concrete. I wouldn't be so consumed with the idea that it's getting worse, that something bad is going to happen. I sometimes just feel like I'm headed towards this big downfall. And I don't know what to do about that feeling because I don't know what's wrong with me.

The need to talk to someone

At the most basic level, women were asking to have someone to who they could turn to if and when they needed them. Someone with whom they could talk to, because, as one woman stated, "being alone and crying is not as effective as being with someone who understands your crying." They identified talking one-on-one with counselors, strangers, sharing circles and group therapy. The women also spoke to the characteristics that would make a good listener: be they Aboriginal, or non-Aboriginal – they need to be respectful, culturally-grounded and trustworthy.

One woman stated, "I think what really helped is that there was someone there" while another woman indicated the importance of "just [having] somebody to talk to about my life." The interview in the project in and of itself was helpful to one participant as it allowed her to talk about what she was going through with her mental health. She stated "long talks, talking like this" help to meet her needs and that it would be helpful for her to express herself like this a couple of times a week.

Maintaining one's anonymity was identified as important. In the case of one woman, like the others above, she understood that a piece to meeting her mental health needs could only be achieved by talking to someone confidentially. However, she stated a preference for that 'someone' to be a stranger. According to her, "you can let out a lot, you can let out all your feelings" without the fear that this will be shared with others.

Some women need to approach their mental health needs through a patchwork of talking, sharing and listening. In the following quote, the woman refers to the need to know that she is not alone with her illness. To hear others and to share with others would be a significant part of meeting her mental health needs. In addition, she speaks to her desire to speak to an Elder as a part of this process.

> *I need to communicate what I'm going through and to hear others' experiences — to share back and forth — mutually, with myself and the support community and others that are in the same boat as I am. The biggest part right now that I'm struggling with is my spirituality, because I want to connect with an Elder, a female Elder, a healthy one that I could talk to here in the city. I'm not sure how to go about that exactly.*

Programs with formal components of sitting and sharing amongst other women, and particularly those going through the same issues, allowed participants to better empathize and understand the challenges they faced, both as individuals and as a group. In each of the accounts below, we hear how many women appreciate the 'sharing circle' format, a safe and comfortable way to listen to other people's stories while at the same time being heard.

- *I think what more helped is my support group, my 12-step group. Because a lot of them came from where I came from. And a lot of them were diagnosed with depression too, and struggling with their addictions and the depression, the mental health issues and stuff like that. It felt a lot safer, you know.*

- *I quit drinking 'cause I'm in this program now and it's kind of helping me 'cause I'm starting to talk about [what happened to me] 'cause we've got a sharing circle every morning.*

- *I feel comfortable there. I just want to stay in there with them and talk with them. I could say anything to them: they understand 'cause they've been in my situation too.*

Women also spoke to the importance of being in programs which included support workers who were either Aboriginal or respectful of Aboriginal people. Moreover, support workers with direct or first-hand experience with their clients' issues made all the difference; they were not simply academically trained professionals but women who had led similar lives. As one woman stated how one Aboriginal women's support centre in Winnipeg was positive for her because she felt understood by the support workers: "Lots of women in the staff were [once] in

abusive relationships ... [T]hey've 'been there, done that,' so they can help you. And it's easier to talk to somebody who's been through that than somebody who's studied it out of the books and lived a great, perfect life."

The women were of mixed opinion as to whether they would prefer an Aboriginal therapist over a non-Aboriginal therapist. In some cases, they had never been attended by an Aboriginal person and so posed the question about whether this would make the difference in the care they would receive.

> *See there just isn't any Aboriginal counselors or therapists. I think that would be really helpful, especially because a therapist is in a position of power. Like I could probably immediately relate more with someone like that because even if this is probably really assuming something, this is probably my own thing, but I could imagine myself in that position more easily because it is more likely that person had similar, a similar lifestyle to me.*

Another woman stated that it may be better to see a non-Aboriginal therapist: "[T]his way they know what Aboriginal people are going through." In other words, it could serve as a learning opportunity for non-Aboriginal therapists. A related thought around learning came from another participant. In her opinion, if non-Aboriginal people are going to work with Aboriginal clients, they should take the time to learn some of their diverse histories and cultural backgrounds. In her opinion, this awareness would not only serve the mental health care professional but also their clients. She states: "they need to expand their horizons instead of being so narrow. Expand their knowledge, like a university credit. If your clients are predominantly Cree, learn Cree history. If your clients are predominantly Ojibwa, learn Ojibwa history."

The issue of trust is key to women, the ability to trust their care provider. Without it, nothing works. One woman who been with the same family doctor for a long time, a doctor who knows her history of partner violence and mental illness, has now developed a relationship built on care and trust. This relationship between health provider and client is truly an example of a best practice of what works.

> *My own family doctor, like, she knows so much of my history and I don't even look at her as a physician anymore. I look at her as a friend because she's not one of those that take you in and check you over and rush you out. Like, she actually takes time and sits with me and listens. And because of knowing my history, and seeing me coming in there battered, and seeing me going through my addiction and battling with that, she always told me that I was very strong and a beautiful woman and I could be doing better. And she was always trying to encourage me and stuff, you know? And I just thought that was awesome, 'cause I've been in contact with doctors that just brush you off ... where I feel [my doctor] has a very nurturing, caring heart.*

Another woman had the good fortune of being supported during her adolescence by a high school guidance counselor, further evidence of how kindness and nurturing

go a long way. She places a lot of emphasis on seeing the same support worker/s all the time, by "not switching it up, so they know you and they're more personal." Contrary to the CFS workers who came and went from her life, she felt that she had a true and constant friend and supporter when life around her was in chaos. She continues to see this guidance counselor to this day, some two decades after their first session:

> *Now we're friends. It's easy to talk to her. … When I was in Child and Family, I was going [through] so many workers, I was like, 'Whatever, I don't care. I'm not going to tell you anything because I'm not going to probably see you next week and you won't remember.'*

The level of trust built up between this woman and her health care provider came literally through years of seeing one another.

The need for care, support and acceptance

Care, support and acceptance can involve good friends, support workers, advocates, traditional helpers, church groups, family and community. As the women move from one point to the next on their journey to mental well-being, each of these individuals and groups will have a role to play in helping her along.

Sometimes the mere fact of someone showing genuine care for one's well-being can go a long way, particularly for individuals who have not experienced affection growing up. In this woman's case, she spent the better part of her life in foster care. She acknowledges that she has lived a rough life and took on negative coping behaviours. Today, she credits the one person in her life interested enough in her well-being for helping her begin the healing process:

> *I have a very, very good friend and he used to be my counselor. When I was so bad into drugs, selling drugs, smoking drugs, doing drugs, working in you know places like crack shacks, I didn't care about anybody. I had no love, I had no feelings towards anybody. … It wasn't about them, it was about my drug addiction, about me. I remember being up for five days straight, and I went to go see my buddy. … He said, 'Well, what is it that you want?' And I was like, 'Do you know what I want? I want to learn.' … I cried and I told him, "I want to be able to open my heart again, I want to be able to love.'*

For some women, support needs to encompass more than the presence of professional counseling. As one woman indicated, what she seeks has more to do with nurturing and encouragement:

> *I have a mentor who half the time does not do her job. I have what people call a support team but I never feel their support. I feel that they are just dictating: that I need to do this, I need to do that. But I don't get the emotional support that I need. I need encouragement, I need love, I need compliments. I need someone to tell me, 'Hang in there.' I need somebody to tell me that it's going to be okay, and I don't have anybody to give that to me.*

Support is defined differently depending on the participant. While the above examples point to the need for genuine caring by support people, other women just need someone to help guide them through decision-making, someone more akin to a support worker and advocate.

> *Sometimes I have memory loss, forgetfulness. Sometimes it's hard for me to make decisions. Sometimes there has to be someone there, to help me, to guide me. And that's difficult because I don't believe in my self-esteem, you know, so it's another stressor.*

Even as women branch out to look for ways of moving forward with their lives, such as going back to school or getting back in the workforce, the need for a supportive resource person or advocate becomes a significant factor in her ability to make those changes happen. Women speak of the distress they feel when that support is lacking. Another issue is when the responsibility is given back to the women. Clearly, they are not reaching out because they want someone else to do the legwork, they are reaching out because they need the help.

> *I was talking to my mental health worker and I said, 'I need your support for me to go to [university]. I need your support and I need your help.' And she said, 'Go research it.' I said, 'I don't know how, I need you to help me.' And she said, 'No, you don't: you know how to do it.' [I]f I did know how, I would be doing it. I need somebody who is going to take me by the hand. And when I say that I need help on something, I don't need it thrown back at my face.*

As almost half of interviewees had approached an Elder or traditional programming and supports for healing, there was a broad range of opinions and perspectives on their roles. Smudging, prayer, and the use of traditions and ceremonies appealed to many of the women and they thought these should be incorporated more into the current mental health programming. When asked whether they believed their mental health would be better served through traditional supports in programming, one woman stated:

> *Yes, it would. I think that needs to be more brought into more people's lives, and I am comfortable with Tradition. Not that I practice or know much about it, but if I could get into that, I would. You know, I would feel more healing coming from it than just going to talk to somebody. I strongly believe in the Aboriginal traditions and ways.*

Women expressed comfort being in the presence of prayer and Elders:

> *Well, I talked to Elders too, yeah. … [T]his woman was at the bus stop; I was talking to her and she was talking and she was praying for me. And I just felt better after that. She gave me a hug. I didn't even know who she was.*

Others have actively searched out specific Elders, even beyond their urban setting, to speak with and participate in their ceremonies.

I just decided I wanted to see an Elder woman in Alberta, I found out about her. So I do want to see this woman and I have hopes that she will be able to help me through her medicines and her ceremony. And then again, I also have fear that it's not going to work anyway.

Other women indicated a general desire to just learn more about what it means to be Aboriginal, including but not limited to traditions and cultural teachings. As we heard in the hopes of one young interviewee, this new knowledge could contribute to a stronger sense of pride in being an Aboriginal woman:

I want to learn history. I want to hear stories. I don't want to hear about the spiritual aspect about it, I just want to know history. I want to understand traditions and why they're traditions. I think that would be really helpful, I think it would give me a lot more pride if I could explain these things to other people. And so, I just wouldn't have to explain, like, 'Oh, well, not all native people are the streets-sniffing-gasoline-man.'

Aboriginal women would welcome the integration of traditional practices. As one woman stated, "Smudging and stuff like that, I just feel that it helps … I think the positive way by healing is doing it traditionally." At the same time, there is a need to understand the fact that not every Aboriginal woman will be comfortable around Elders or traditional ceremonies as supports for improving mental health. The following example shows that despite the desire to know more about her identity, this woman feels internalized confusion when traditional teaching are brought up.

Every time I hear 'Aboriginal,' something inside me tenses up, because, in my blood I'm an Aboriginal, but I was raised in a white family. So [the teachings] that [another focus group participant] was talking about, I just sat there like she was speaking Chinese, because I can't relate. I wasn't brought up like that. I don't know what it means to be Aboriginal. I would love to learn my culture, but I don't have anybody to teach me what it means to be Aboriginal.

Aboriginal women come and will differ as to the personal usefulness of western or traditional-based healing practices and medicines. While they still respect traditions and practices, their needs took them in a different direction.

I'm not exactly a traditional Aboriginal person. And I found that, in approaching some of those agencies, the counselors that they have on hand are actually non-certified Elders who just tell me to smudge and pray. And I think I need something a little more definitive than prayer.

Another woman raised cautions as to who the truly respected traditional people are in the community. There have been times where women have been taken advantage of in traditional settings, prompting this interviewee to warn of those who would make money and potentially make sexual advances on unsuspecting participants:

But you have to be careful because some ceremonies or some traditional people are the 'hey-yah, hey-yah' people. Some of them do use you: to say it bluntly,

they want to just fuck you. And that is not really what it's there for. Like, you have to know who are the sincere ones in the community that don't use their 'hey-yah, hey-yah' on you to gain power, to gain money.

While not meant to show disrespect for traditional practices, ceremonies or Elders, these perspectives do indicate that some Aboriginal women will seek out other supports, such as Christian-based groups. It is important to remember the great diversity amongst the Aboriginal population. As stated by Caroline Tait:

Not every Aboriginal woman would go to what we would call traditional healing programs. We see this all the time, people who are Christians, very strong Christians who may not embrace traditional methods of healing. They may not want to go in sweats, they may feel excluded then from services…They get support from their church…Some people go back and forth and it doesn't bother them.

Family and community were also identified as an "intricate" piece of the support networks Aboriginal women need as they move forward in their healing. Yet they also acknowledged the negative impacts of their mental illness on their immediate families. This final piece to this section will look to these impacts and the centrality of supportive environments, including ties to communities and relationships with friends and family, which cannot be underestimated as a factor in the mental health and well-being of individuals.

The majority of the women (10 out of 17) drew possible links between mental illness and family violence/abuse, with the impacts felt most notably by children. Relationships between mothers and their children ranged from very close to tenuous to no contact at all. In homes with multiple children, the women pointed to different behavioural responses to their mother's mental illness.

One woman spoke emotionally about her own children, each of whom has displayed a different response to her depression and suicide attempts:

My older son, he would talk to me, and we're really, really tight. I call him 'my bear,' and I remember him being in the living room on the rocking chair and saying … that I was very smart and beautiful and, and he didn't want to lose me and he didn't know what he would do without me … and that I have a lot to live for. And then I have my younger daughter, who started staying away from home because she was afraid of what she might walk into, [not knowing] if her mom would be alive or dead. She was really scared: she expressed that too.

Turning to her eldest daughter, the woman sees the older girl's use of alcohol as a possible means of coping, and understands her depression may have an effect on this child, who could be patterning behaviour similar to her own:

I don't know if my depression steered my other kids. Like my oldest daughter, what she's going through, like she has a drinking problem. I don't know if I added to it you know, because although she might say, 'Oh well, that was the

past" … but I know it goes deeper than that. … [I] was really good at
camouflaging a lot of stuff, so my daughter does that very well, and I pick up on
that, but I don't push the issue. I do talk to them about a lot of things that have
happened in their lives that I really feel that need to be addressed and talked
about.

Witnessing attempts at suicide would be difficult at any age but, for children, it can
be even more profoundly traumatizing. As with many such traumas, a variety of
coping strategies come into play, during and after the event. One woman spoke a
little to how children's strategies evolve as they move into adulthood:

Because I had attempted suicide, I had slashed my arms up and stuff and it was
even before that actually, because I was trying to overdose on pills a couple of
times. One time I just sort of lost it, and I just cried on the phone and said, 'I
can't do it anymore.' I think that was when I was about 25, 26. I just
remembered sitting in the middle of my floor crying with… my two daughters.
And my oldest one helping the younger one because I was useless. Now I find my
youngest daughter is sort of following the same ways, the same patterns. She's
on anti-depressants right now. I don't think they're doing anything for her,
really. She's a lot like me, but her personality is totally the opposite [from] mine.
She's extremely outgoing and loud. Forceful, strong and scary; yeah, [she] can
be violent. Very violent. I myself was like that… wanted to hurt myself. She's
doing that as well.

Another participant also made the links between her own behaviour and that of her
daughter. The participant explained her violent outbursts and thoughts around
suicide. She stated that when there was no one to fight, "they'd lock me in the room
and I'd stay there. I put holes in the walls and yelling and kicking and screaming,
saying I want to die, I want to kill myself." These are the very same actions now
being displayed by the next generation in her family.

[My daughter's] following me too: like, the way she acts sometimes. … She pulls
her hair. I used to do that when I was young, and now I see her doing that when
she got so mad. And she's kicking the wall and everything … I used to do that
too…

As women who had mothered under mental duress and distress, they later
expressed considerable emotion, self-blame and guilt over the lifelong impacts of
their behaviour on their children. As we hear in this story, marriage breakdown and
poor birth outcomes of her children only compounded such impacts for one family:

It really hurts. I think they felt abandoned. I probably wasn't the mom I
should've been. I've been feeling that all of my life. I feel guilty because of the
breakups that they had to suffer too. I know for a fact it affected all of them.
With my husband, we broke up. I was totally devastated. I went down to 95 lbs.,
I got pregnant and I just about had a miscarriage. I carried my baby not even
to term. He was born blind. He was affected because of my mental health. So did

all of them, one way or another. I probably wasn't helping my oldest girl, because the dad left me and I tried to take care of myself. But, like I said, it was a very dysfunctional family and I blame myself because my daughter, she will never be the same. She has brain damage from when she was small because something happened in my womb.

Certainly, the women understand that their mental health has had an impact on their families. Yet they expressly state the need for family and community support as a mean to keep going. One participant, who struggles with severe clinical depression and continuously battles thoughts of suicide, holds onto her partner for day-to-day survival: "Oh, god, if I lost that, I don't think I could cope anymore. That would be it. I'd be doing the big Fuck-It dance. That would be the end of it."

In this situation, her partner is her lifeline. While this example clearly points to the need for family support, it also reveals the potential stress of being the primary support person for a partner with mental illness.

In a similar vein, one of the participants spoke of being institutionalized at a mental health centre. While dealing with episodes of manic depression and suicide attempts there, her mother and sister would drive every day to see her. For her, these visits (in addition to praying everyday) "saved" her, and helped her to move forward with her healing.

When describing her social networks, one participant stated that without her family "I would have nothing." When asked about the importance of community support, she states: "I love being there. I can just go there and have coffee and I know everybody there so I always got a friend to talk to and, yeah, they support me. I don't know what I'd do without them either."

For the women we spoke to, the ability to communicate their mental health issues with family is vital, not only because it allows the individual to verbalize their struggle but allows the family and community the opportunity to understand what is happening in the life of a loved one. As one woman put it: "I think there's no way around [communication]. It's an intricate part of [family support] because whatever you're going through, they're gonna go through that too. I found that out. As long as I can keep the communication going, it's okay."

Acceptance was brought up by a number of women. While some told of family barriers due to denial of their mental illness, others spoke of how family and community acceptance was integral to moving towards mental well-being. In the words of one participant,

The biggest support that my family can be to me is to understand what I go through. So when I educate them about my addictions or my bipolar disorder they're more understanding and respecting, and encouraging. The other thing I'm grateful for is that they have acceptance of me, wherever I'm at. I get words of encouragement, and I get comments and questions of concern.

Importantly, family support in one setting may be very different in another. Still with this same participant, whereas she receives positive encouragement from friends and family in her urban dwelling of Saskatoon, it is different when she goes to her home community, where she and her illness are labeled and misunderstood:

> *And so when I go up north for periods of time, to my own reserve … and the other reserves, then I get a different response about my conditions. People understand the alcoholism. People understand the depression, because there is a lot of depression on the reserves. But it's not always acknowledged or dealt with. Number one coping mechanism for dealing with depression way up on the reserves is substance abuse. Drinking or smoking up all the time. So then when my family and friends up north have seen me going through hypomania or mania, and then I try to explain to them what it is, I'm just written off as crazy, no matter how I try to explain that I didn't 'cause it, that it is in my family to some extent. … I don't have schizophrenia. I have bipolar disorder, which is basically a mood disorder. My moods fluctuate extremely and I'm not crazy. But I've had to fight the image of that, or the stigma of that. And then, when I am doing well because the medication helps greatly with that, to stable my moods, then my family in the north, they are totally against me being on pills. And they would get mad at me and say, 'Oh, you don't need those pills! You're fine. There's nothing wrong with you.' And it's because of the medication a great deal of the time that I have periods of stability.*

Certainly, while family and community support are necessary, they are by no means easily achieved. There is the need to raise awareness about mental health generally, but also focus on how family and communities can be conduits for better mental health outcomes for women. That said there is also the need to recognize that families and communities themselves also require supports in this role.

SECTION SIX

CONCLUSION
ABORIGINAL WOMEN ENVISAGE "KNOWING MIND *FULLNESS*"

> *What is it that needs to be put in place so things don't go wrong?*
> *That at the end of this intervention, she is left minimally the same or optimally she's better off than when she entered.*
> — *Caroline Tait*

In conclusion, while there was no consensus about the "right" or "most effective" program or service, women clearly articulated concrete and pragmatic recommendations about how they would change the mental health system to better meet their needs. It collectively adds up to a care system that is collaborative and draws upon both Traditional and Western-based approaches. Their experiences with the mental health system point to a shared need to be heard, believed, and treated with respect. This ideal system would also promote culturally appropriate, safe care while staying away from a cookie-cutter approach that fails to account for the diversity of Aboriginal peoples. This final section highlights these women's recommendations and concludes with specific policy implications.

VISION: Listen to the community for solutions on improving mental health

- *Communities will tell you what works.*

- *I really think that we need to look at programs and services and what's being offered. I firmly believe in intervention research. I think that people often know what works in their community. And taking seriously the idea that the answers are in the community, we've talked a lot about that but I don't think we've ever taken that seriously. If you take it seriously, you don't just go in there, have a meeting and they would tell you what is working and you try to create a project. What really needs to happen is that a whole bunch of things have to happen at the same time and there should be evaluations of any intervention.*

VISION: Develop more early intervention programming

To begin, there was a recommendation to implement early intervention programs.

- *I think there needs to be more extracurricular activities, like free or subsidized or something, because I never had anything of that when I was growing up, like after school activities. Sometimes I would stay at school until it closed, so I*

wouldn't have to go home and things like that. I would just sit in the library and it's not very fun. I never made any friends that way. I think if there were programs that I could go to after school that were close by that were free, even just like sports or a little art class or something, it would have been really interesting. Just people having fun, a little place like a daycare but you don't get dropped off you can leave.

VISION: Break down the barriers to finding mental health support and help

- *[Making it so it's] not such a difficult time getting in just to talk to someone; you know, that thing about referrals and the steps ... [T]here's so much red tape and sometimes so much politics, red tape, bureaucratic crap. People don't want to take the time to do it, they don't. They just give up and then they're just wondering around aimlessly, you know, and that's sad. And then we wonder what happens to them or if even if people are aware what's going on. I don't know, I wish there was such a thing as a perfect system.*

- *Well, one of the things is not to have a waiting list. Training: to include more training ... specifically with mental health. I mean, there has been training in the past, but I think it needs to be ongoing. Yeah, a facility where they can go to. I mean, we're a small ... 21-bed unit. We can have fifteen women and the rest children. There needs to be a place where they can go and stay where they're not waiting and waiting and waiting. That's what I see as a perfect world for Aboriginal women with mental health. And somebody to work with them [individually].*

VISION: Make sure that mental health resources and information are available to Aboriginal women and the community at large

- *I don't believe there's enough information out there.*

- *Have a resource book like all the Aboriginal agencies have: that has the name of the company, where it is, its contact information, all the resources that it offers. Why isn't there that? There's a mental health guide that comes out once a year, and it doesn't even tell you what all these listed resources are for.*

VISION: Create around the clock, in-person mental health care

- *'Cause it's very important not just to call a flippin' phone number: [when] you're in crisis, that's not good enough. I think an actual place where a person can go, if they're in crisis, and have that door open, 24/7. That would be really, really, outstanding. That way, you know, you feel ... you can go to a place and ... you're not standing on the street alone wondering which direction to take. You have a place to go. And you're ... welcome there, you're comfortable there, you're loved there ... you're a person there.*

- *I would really love to see some place for women, whether it is a healing centre, or something where there are clinicians that are available to the ladies 24 hours a day so they know they can go when they're in crisis because it's not 9 to 5, Monday to Friday. In the middle of the night, when things are closed, and you know, that's when crisis happens. Either they can pick up the phone, or grab their kids and come out and the door's open and the coffee's on and somebody's there.*

VISION: Increase culturally-appropriate programming for Aboriginal women

- *It has to be culturally appropriate for sure, because if you already feel that other people don't understand you, you're not gonna be able to open up.*

- *To open up more Aboriginal programming for the Aboriginal people because a lot of us just don't fit in the community or into the system (the White system).*

- *I don't know, maybe something like this [space], that's comfortable. Like, all the Aboriginal stuff … I was scared I was going to walk into, like, an office type building … [but] it's comfortable more like this, 'cause this is what my home looks like. Have lots of stuff like that … a peaceful place that reminds you of your own home.*

- *I think there needs to be more outings; like, something that would make you feel important. You know, you're part of the community, you belong. Like, going out onto the land and learning how to make a fire from flint. And, you know, making a fire and going sitting out there for a little while underneath a tree … and just sit there and meditate for a while. And, then come back into the group and share your experiences. I think there needs to be more interaction that way, 'cause it kind of brings back the land and who you are as an Indian woman.*

- *If there was more Aboriginal people to be counselors, social workers and therapists, that would be … a substantial step forward. For them to be able to go to somebody like that, that is part of their heritage and their culture and knowing a lot of the background. … A center for people with mental illness would be something that is very important to maybe come about one day, hopefully. Especially with the culture and traditional alongside with it, the healing beliefs and that.*

- *More programs with the medicine wheel.*

VISION: Promote more opportunities for healing

- *More time for talking circles*

- *[You need opportunities where] you can feel comfortable and feel that peace of mind for just that short period of time. You know what I mean? To feel safe, and*

to feel that things can get better. Where you do have hope, you can succeed, you know?

- *They should have a place where, like, someone could go talk to [counselors]... you could smudge if you feel bad and just go into this room and go talk to somebody. But to soothe yourself.*

- *Like in our little group, like this, we're able to feel safe enough to be able to ... expose ourselves in a personal way ... [E]ven being able to sit in a circle like this has been heart-warming ... [listening to other] women's issues and ... how we have a lot of commonalities.*

- *I think there's a huge, huge benefit to what has happened in the country in terms of healing programs. Community based healing programs are wonderful in that many women have reported...how much they benefited from this type of program.*

VISION: Develop a one-stop mental health clinic

- *I'd like to say that it would be like a clinic. There'd be drop-in resources for counseling, where you could get immediate help. I'd also like it to be more tier-based, so that, after speaking with a counselor, you could speak with someone of higher authority and not just ... somebody else at the same level. So if you could start with a counselor or a therapist, you could end up seeing a psychiatrist at the end of it, if you really needed to.*

- *One stop shopping health services centre ... where you can go in and you can spend a day. You go in and you can travel around, and you did dental services, you get mental health services, you get doctor services, you get physiotherapy, and child care, so that everything is done all-in-one ... [Then] you're dealing with the whole person and everything gets done. Everything gets treated, and that person leaves feeling well taken care of, respected, and wanted. And it's done in the community: you're not taking somebody out of their community.*

VISION: Build a collaborative care model for mental health

- *I think there needs to be a main base organization dealing with Indian people that employs Indian people, that recognize and understand Indian people. But they could also work in partnership, they could work with other communities and organizations: like, Manitoba Schizophrenia Society, Canadian Mental Health Association or Mood Disorders Association.*

- *And there needs to be that connection with community and partnerships. [I]n our Indian organizations, we need to ... see if they could help us through housing, employment, or getting clothing, or certain different things, you know. Stuff like that. It's just bare essentials. Just everyday living stuff.*

- *I really thrive on going to programs. They help my issues. With more community programs out there for Aboriginal women, doing the medicine wheel would help us so much more, I think, because I've tried AA, I've tried other things, and they don't work for me. And when I came here, to this building, and actually lived here for eight months, I've learned more about myself than I've ever have in my whole life. Because I am a true Aboriginal woman, and I know where I come from, and I'm very proud. Like, I've been sober now for almost five years ... I have my daughter ... and it's through the help of this program and them teaching me ... Western medicine and traditional medicine. I've had an Elder tell me, 'Take both.' You cannot live without both ... I was confused ... But then when she said, 'No, you're diabetic, take your medicine. Take your medicine.' Still smudge and pray, you know, still do that. Still do the things that you need to do to survive.*

VISION: Raise awareness around mental health

- *There needs to be more awareness in families and within communities. Maybe on APTN there could be a doctor or someone that could go on and talk about mental health issues or alcohol or addictions, 'cause it's all inter-linked.*

- *There needs to be understanding about mental health. I'm living in a group home for mental health and my care givers do not understand what mental health means. They don't have a clue.*

- *I need them to understand that if I'm depressed, I need a hug. I need someone to tell me, 'It's okay, don't give up. Don't go jump off a bridge, don't go kill somebody.' That it's going to be okay. I don't need to be yelled at, I don't need to be criticized, because I have mental health issues. I feel that there is no understanding of mental health. Mental health, there is no empathy.*

VISION: Provide more programming focusing on life skills development

- *Places to go: like, an organization to help you learn how to cook, or what type of diets you should be on, or learn how to recycle garbage... educational programs that may be able to benefit you in life.*

- *[A] facility [that] helps you to enjoy life, to look at sunsets, sunrises, to deal with the land, oral stories ... [led by] sincere, educated Indian people, that know who they are. ... And, being able to learn how to relive again. Like, I know they have shelters out here in Winnipeg ... [where] you live in there for 2 years or a year ... to help you get back on your feet. Learn how to cook, shop, and just manage yourself again.*

VISION: Create more drop-in centres for Aboriginal women

- *More organizations, more agencies, more programs. Education, counseling, a drop-in centre for women that need to do their laundry … a place to come hang out, to stay off the streets. A shelter: more shelters. And more tradition.*

- *I wish we had a place where a woman can go, just to have evenings out maybe … just do knitting … bead work or something. And also a place where somewhere they can leave the kids. And maybe, like, how to eat properly… like, a wellness place. Maybe some weights and exercise equipment.*

- *There's a lot to be said for women's groups. I think that women supporting women, community women's groups that get together and cook together… sew together, do things that are unrelated to mental health, but have everything to do with mental health and support and caring are wonderful interventions or supports that should be encouraged more. In particular I would say for the young women.*

VISION: Increase opportunities for mental health aftercare programs

- *That as a society was providing programs and services and the health care system that it would be unethical for her to leave that treatment program without some kind of plan, with a meaningful plan.*

VISION: That adequate and long-term funding is provided to mental health programming for Aboriginal women

- *I think the government needs to change; they need to change their funding practices. This idea that government doesn't like to change or doesn't want to change, I know that but I think that it can change. What I would like to see is Aboriginal people leverage their collectivity; I know we are dividing in so many ways. To almost say, we reject any programs or services unless they're based upon sound ethical standards that protect vulnerable people. We collectively stand up and say no, we are not participating in the ways you are throwing money without proper planning, without consideration of what happens as time goes on and you yank out the money.*

Policy Implications

1. Examine how cultural (relationships) and structural (policy) level changes can be made to serve and support the mental health and well-being of Aboriginal women in the changing policy climate.

Cultural changes

  i. Catalyze conversations on everyday forms of mental health and well-being to determine what is working for Aboriginal women in their everyday lives.

  ii. Valorize the stories, experiences, knowledge and wisdom of Aboriginal women who live with mental health problems and illnesses.

  iii. Bring into sharper relief the optimism, pragmatism, resilience and human agency of Aboriginal women living with mental health illnesses.

  iv. Understand the impacts of residential schools, foster care and the bio-medical model of health care lived by Aboriginal women by taking a critical look at multiples risks they experience and the protective practices they, their families, and communities of care each utilize.

Structural changes

  v. Factor in gender, sex, cultural and class differences for Aboriginal women with lived mental health experiences in order to better define, identify and remedy their health disparities and inequities.

  vi. Provide mental health services and supports to Aboriginal women close to home by encouraging the practice of home visits by caregivers.

  vii. Monitor and use ready, relevant and multiple interventions for Aboriginal women by acknowledging and working with what they say has worked best for them to date without over-medicalizing their mental health problems or over-pathologizing their responses.

  viii. Cultivate a sense of belonging, usefulness and importance amongst Aboriginal women with lived mental health experiences.

2. **Conduct research on the meaning and application of an Aboriginal lens when addressing the mental health and well-being of Aboriginal women.**

    i.   Deepen the public understanding of the worldviews of Aboriginal women emphasizing the wholeness of the mind, body and spirit but also by examining the women's views of the world which they generally experience as unjust and unfair socially, economically, culturally and politically.

    ii.   Wherever possible use Aboriginal concepts and emerging community-based practices to explain mental health and well-being of Aboriginal women and to determine the ethical and healing aspects of these.

    iii.   Invite Aboriginal women with lived experiences to develop interactive learning tools for their health care providers, families and one another (i.e. role plays, poetry, art, songs that would incorporate oral traditions and examples of mental health and well-being).

    iv.   Utilize a gender balanced framework in further research on Aboriginal women's mental health.

3. **Reframe mental health services and supports so they mirror Aboriginal women's realities, living conditions and aspirations for hope and recovery.**

    i.   Improve Aboriginal women's access to mental health services and supports and enhance their attachment to these by creating compassionate, solidarity-based, trusting and confidential programming.

    ii.   Explore the multiple burdens of stigma and discrimination that Aboriginal women face, including self-stigma and racism, to see how cultural competency and cultural safety can help to offset these.

    iii.   Recognize that the social roots of mental health problems stem from deep, long-standing childhood trauma, including sexual abuse, poor infant bonding and attachment and from current issues like homelessness, poverty and suicidality and how these can lead to a cluster of chronic mental health and physical health problems.

    iv.   Reflect nested identities (i.e. ethnic, cultural, religious, abilities etc.) by tailoring services and supports to the particular needs of Aboriginal women-in-community to avoid pan-Aboriginal approaches and cookie-cutter interventions.

4. Develop mental health services and supports from evidence-based practice and practice-based evidence.

    i.   Fully integrate the ideas, interests and perspectives of Aboriginal women into the design, delivery and evaluation of mental health services, supports and programs.

    ii.   Offer both Traditional and Western healing approaches to Aboriginal women and assist them once they make a choice by providing transportation and childcare services and by paying attention to the power relations they have to deal with.

    iii.   Emphasize mental health promotion and mental illness prevention along with diagnosis and treatment by providing mental health literacy training for health and social services professionals and mental health first-aid training to family and friends.

    iv.   Advocate person-centered care for Aboriginal women with lived mental health experiences and direct initiatives to them including peer support and interactive learning opportunities.

    v.   Recognize the prevalence of the co-morbidity of mental health problems and addictions by drawing on studies and looking for gaps in knowledge, resources and capacity.

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APPENDIX 1

Aboriginal Women and Mental Health: A Gendered Perspective

INTERVIEW GUIDE

Demographic Information

1.   Can you tell me how old you are right now?

2.   How do you identity yourself as an Aboriginal woman?

3.   What is the highest level of education you have completed?

4.   What is your current employment status?

5.   What is your main source of income right now?

6.   What is your approximate yearly household income?

7.   Do you have any dependents currently living in your household?
8.   Are you currently living on your own or with a partner?

Childhood Experiences

9.   Can you tell me a bit about yourself in terms of where you grew up and the type of family that you grew up in?

10.   Can you describe for me what life was like for you in your childhood and teenage years?

11.   What kind of experiences with alcohol or substances did you have while you were growing up?

12   What about violence? What kind of experiences with violence or fighting did you have while you were growing up?

13.   Do you ever remember a time when you were treated differently because you are Aboriginal?

14.   Could you describe the circumstances surrounding the first time you left home?

15.   In looking back on your childhood and teenage years, what kind of effect, negative or positive, would you say your experiences had on your life?

Personal Experiences with Mental Health

16.   How would you describe your own physical health?

17.   How would you describe your own mental health?

18.   What does mental health mean to you?

19. Have you ever had any concerns with your own mental health? What about now?

20. When did you first become aware that there was a problem with your own mental health?

21. Have your mental health concerns ever been diagnosed? By whom?

22. Did you ever look for help in dealing with your mental health concerns? What was the result? Did you ever get the help you were looking for?

23. Did anything ever stop you from getting help for your mental health issues?

24. Are you currently receiving help for your mental health? What kind of help are you receiving?

25. Why do you think you have problems with your mental health? What are some of the underlying issues linked to your mental health concerns?

26. Do you think your mental health concerns are linked in any way to your history of colonization and residential schooling?

27. Have you ever thought of yourself as being mentally ill?

28. Do you think people have a negative attitude toward you because of your mental health issues?

29. Do you think you are treated differently than non-Aboriginal women with mental health issues? What about in relation to Aboriginal men and non-Aboriginal men with mental health concerns?

30. What kind of effect do your mental health concerns have on your family? On others in your community?

31. What kind of effect do your mental health concerns have on your identity as an Aboriginal woman?

Coping Strategies and Resources

32. What are some of the things you do to take care of your mental well-being?

33. How important is it for you to have family support in dealing with your mental health issues?

34. What about support from your community? How important is that to you getting better mentally?

35. What are your mental health needs?

36. What do you think about the services and resources that are currently available to help Aboriginal women with their mental health? Can you identify any problems with these mental health services?

37. In terms of policies and practices that affect Aboriginal women, what is the most helpful thing we can do to meet your mental health needs as an Aboriginal woman?

APPENDIX 2

Aboriginal Women and Mental Health: A Gendered Perspective

FOCUS GROUP GUIDE

Understanding Aboriginal Women's Mental Health

1.   What is mental health?

2.   How would you define Aboriginal women's mental health?

3.   What might be some of the mental health concerns for Aboriginal women?

4.   What are some of the underlying issues linked to Aboriginal women's mental health?

5.   In what ways can Aboriginal women's mental health be linked to their history of colonization?

6.   How would you describe an Aboriginal woman with mental health concerns?

7.   How do you think people look at Aboriginal women with apparent mental health concerns?

8.   Do you think that Aboriginal women with mental health concerns are looked at differently than non-Aboriginal women with mental health concerns? What about in relation to Aboriginal men and non-Aboriginal men with mental health concerns?

9.   Do you think there is a negative attitude attached to Aboriginal women with apparent mental health concerns?

10.   What kind of effect would an Aboriginal woman's mental health concerns have on her family and on other individuals in her community?

11.   In what ways might mental health issues affect the identity of an Aboriginal woman?

Coping Strategies and Resources

12.   What are some of the things Aboriginal women do to take care of their mental well-being?
13.   How important is family and community support for Aboriginal women who are struggling to overcome mental health concerns?

14.   What are some of the underlying issues that might keep Aboriginal women from getting help in dealing with their mental health concerns?

15.   What do Aboriginal women need to help them with their mental health concerns?

16. Can you identify any problems with the mental health services that are currently available to help Aboriginal women?

17. In terms of policies and practices that affect Aboriginal women, what is the most helpful thing we can do to meet the mental health needs of Aboriginal women?

APPENDIX 3

Aboriginal Women and Mental Health: A Gendered Perspective
INTERVIEW GUIDE FOR ELDERS

Work-related background

1. How long you have been working with Aboriginal women in the community?

2. Can you tell me how you would define mental health and mental well-being?

3. Do you think that our communities experience a lot of mental health issues?

Mental Health

4. In your work with women, do you see common mental health issues affecting them?

5. Would you say there is a link between violence, or substance abuse or childhood trauma which affects mental health of Aboriginal women?

6. Would you say that the mental health of Aboriginal women has been affected by the history of colonization and/or the residential school system?

7. How have you seen Aboriginal women cope with their mental health issues?

Traditional Aboriginal Knowledge

8. Can you tell me about cultural and/or traditional understandings of mental health?

9. Is there a word for mental health in your language? What is this word and can you explain it?

11. How important is it to be familiar with Aboriginal culture (traditional healing practices/medicines/songs/ceremonies etc.) when working with Aboriginal women and mental health?

12. What traditional healing practices do you use in your work with women?

13. Do you think that Aboriginal women would be better served by cultural and traditional ceremonies to heal from mental health issues? In your view, are these available to them?

Services

14. Do you think that Aboriginal women respond differently to the help they receive compared to other populations?

15. Would you say that Aboriginal women get the help they are looking for and need?

16. What do you think about the services and resources that are currently available to help Aboriginal women with their mental health issues? Are these adequate?

17. What needs to change in terms of policies and practices to best meet the needs of Aboriginal women and their mental health?

18. Do you have any additional comments?

APPENDIX 4

Aboriginal Women and Mental Health: A Gendered Perspective
INTERVIEW GUIDE FOR FRONT-LINE WORKERS

Work-related background

1. How long you have been working in the mental health field?

2. What is your educational background?

3. Why did you choose to work in this field?

4. How would you define mental health and mental well-being?

5. Are the majority of your clients Aboriginal?

Mental Health

6. Are there common mental health issues affecting the Aboriginal women you work with?

7. Do you see a link between violence experienced and the mental health of the Aboriginal women?

8. Are problems related to substance abuse common among the Aboriginal women that you work with?

9. Are traumatic experiences in childhood and youth common to the Aboriginal women that you work with?

10. Do you see similarities between the Aboriginal women's backgrounds and/or situations which affect their mental health situations?

11. Can you identify any issues related to mental health that are specific to Aboriginal women?

12. Would you say that Aboriginal women are affected by the history of colonization and/or the residential school system?

13. How would you say Aboriginal women cope with their mental health issues? Could you explain what you've seen Aboriginal women do to take care of their mental health and well-being?

Traditional Aboriginal Knowledge

14. How important is it to be familiar with Aboriginal culture (traditional healing practices etc.) when working with Aboriginal women and mental health?

15. Do you incorporate traditional healing practices into your work? Do you know of other community supports where women can go to receive such services?

16. To what extent do you think that Aboriginal women rely on their communities and/or families for support in dealing with their mental health issues?

Services

17. Do you think Aboriginal women tend to approach the health-care system in a different manner than the general population?

18. Do you see a difference between Aboriginal women and the general population regarding the length of time between acknowledging a mental health issue and seeking help?

19. In your opinion, are the mental health issues experienced by Aboriginal women different from other people?

20. Do you believe that Aboriginal women vocalize their mental health needs? Do you think the mental health system appreciates the unique needs of Aboriginal women?

21. Do you think that Aboriginal women respond differently to the help they receive compared to other populations?

22. Would you say that Aboriginal women get the help they are looking for and need?

23. Do you think Aboriginal women are treated differently within the healthcare system than non-Aboriginal clients?

24. Do you think women receive different care than men?

25. What do you think about the services and resources that are currently available to help Aboriginal women with their mental health issues? Are these adequate?

26. What needs to change in terms of policies and practices to best meet the needs of Aboriginal women and their mental health?

27. In your opinion, is there a need for more direct services for Aboriginal women? How would these be different than what is currently available?

28. Do you know of situations where Aboriginal women have encountered barriers (communications or others) when seeking out mental health services?

    If yes: How do you think that could be changed?

29. Do you have any additional comments?

APPENDIX 5

Aboriginal Women and Mental Health: A Gendered Perspective
INTERVIEW GUIDE FOR RESEARCHERS

Work-related background

1. What is your educational background?

2. Why did you choose to work in this field?

3. How would you define mental health and mental well-being?

4. Could you provide an overview of the research you have been involved in regarding Aboriginal women and mental health?

Mental Health

5. In our research, Aboriginal women have spoken about multiple trauma, loss and separation (ie. colonization, residential schools and the intergenerational effects, family disruption, CFS, violence etc) as contributing to their mental illnesses. Would you identify other common roots which affect Aboriginal women's mental health?

6. Has research thus far adequately identified any specific roots of mental health issues of Aboriginal women and their coping strategies?

7. Do you believe there has been enough research and study dedicated to understanding mental health, mental health services and mental health programs for Aboriginal women?

Services/Programs:

8. Do Aboriginal women approach the health-care system in a different manner than the general population regarding their mental health?

9. Do Aboriginal women vocalize their mental health needs? Do you think the mental health system appreciates the unique needs of Aboriginal women?

10. Do Aboriginal women respond differently to the help they receive compared to other populations?

11. Would you say that Aboriginal women are getting the help they are looking for and need?

12. What do you think about the services and resources that are currently available to help Aboriginal women with their mental health issues? Are these adequate?

13. What needs to change in terms of policies and practices to best meet the needs of Aboriginal women and their mental health?

14. In your opinion, is there a need for more direct services for Aboriginal women? How would these be different than what is currently available?

15. Do you know of situations where Aboriginal women have encountered barriers (communications or others) when seeking out mental health services? If yes: How do you think that could be changed?

16. Can you comment about the practical application of recommendations for programs and services?

17. Could you comment on research gaps specific to Aboriginal women and mental health?

18. Is there a role for traditional knowledge in mental health and healing for Aboriginal women?

19. Do you have any additional comments?

APPENDIX 6

PWHCE PROJECT TEAM MEMBER OBSERVATIONS ON

RESEARCHING MENTAL HEALTH SERVICES AND PROGRAMS IN WINNIPEG

As follow-up to the project, PWHCE hopes to develop a more user-friendly guide to the mental health services and supports in Winnipeg and Saskatoon. One piece of this was to find out which programs and services currently exist and what are the steps for accessing them. A student researcher was tasked with calling the different services and programs located within the Winnipeg Mental Health Guide. The following is a summary of her experience doing this research:

As someone who has had zero experience in this area, I found the process of negotiating through the mental health services offered in Winnipeg and Saskatoon quite challenging. However, this allowed me the opportunity to better understand the feelings, challenges, limitations and, at times, frustration that many of the participants in the study had described. I immediately discovered that cold calling the various centres and clinics was not ideal, as those on the other end of the line seemed busy and eager to conclude the call. Often I would not have the chance to ask any/all of my questions.   On a few occasions, the person I spoke with, while helpful, directed me to another person/phone number and clearly misunderstood what information I needed, as the next person I spoke with could not be of service to me. At that point I was too put out to call back the original person I had spoken with, so that centre or clinic was unfortunately off my list (or at least at the bottom of it). On several occasions, the person on the line transferred me to another person at the centre/clinic and I simply received their voicemail, which felt like another dead end. However, I did receive a call back from almost every place where I left a message.

After the first few phone calls I stopped introducing myself, and simply asked about their services. Not knowing who I was, many of the people I spoke with seemed hesitant to give me any information. Some demanded to know who I was and one centre even insisted on getting my first and last name before answering any questions, so those hoping for anonymity may be intimidated. Others kept reiterating that one had to be a resident or member of the program or centre to receive any services but did not go any further to explain how one could accomplish that.

Many of the places I contacted had either long waits, charged for their services, or had very specific requirements for those wanting to access their services or programs. I was calling as someone without specific needs or a diagnosis, which I knew would make it more difficult for a stranger on the phone to direct me to the right resources. However, I realized that many of the participants from the study were also undiagnosed and therefore did not know what their specific needs were either. At that point I was able to really imagine obstacles that the women described.

I also began to ask some of the centres to recommend other places that I could get in touch with. Few of them seemed to know of many other resources available or if they did they were unsure or misinformed about the specific services that they offered. One person directed me to the Health Links phone number for someone looking for a diagnosis, while another individual explained that the line only dealt with specific biological health issues. That same person would only give me one word answers when I inquired about counselling services and demanded to know who I was. Again, for an individual hoping for anonymity and patience, this could have been a barrier. Understandably some of the individuals that I spoke with were hesitant to give me information as an outsider, or someone who was not specifically accessing their services and so asked that the individual requiring help be the one to call them directly.

The ability to research a centre or clinic on a computer prior to calling them certainly reduced some of the anxiety associated with cold calling. I was particularly anxious about calling those places without web sites. It is not hard to imagine that those without access to a computer or the Internet would have a much harder time accessing information about the programs and services. In fact, after calling and researching each place it was often much more informative to visit the web site. It also became apparent that the mental health resource guide did not offer nearly enough information regarding the specific services and program requirements for the various clinics, centres and other services. That is not to say that the entire experience was negative. Many individuals that I spoke with were incredibly helpful, kind and informative. A few also empathized that the current system was not ideal. The directors of the drop in centres were especially friendly and more than happy at the chance to have new members to show up for their crafts and cooking classes, or just to socialize. However, after spending nearly thirty hours researching these sources and still not completing an exhaustive compilation, it is not hard to imagine others becoming frustrated with the process of finding the appropriate help.